STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365218	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ash Care Center	4900 Cooper Road Cincinnati, OH 45242

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on record review, interview, and policy review, the facility failed to ensure a resident was provided the correct diet texture. This affected one (Resident #52) of three residents reviewed. The facility census was 55. Findings include: Review of the medical record for Resident #52 revealed admitted [DATE]. Diagnoses included pneumonitis, anxiety disorder, type two diabetes, hemiplegia, and hemiparesis. Review of plan of care dated 12/10/24 revealed Resident #52 was at risk for nutrition and hydration problems related to diabetes mellitus, schizoaffective disorder, bipolar, need for nutritional supplements, supervision for all meals, nosey cup with drinks, and need for mechanically altered diet and thickened liquids. Interventions include allowing residents to make choices, or preferences, observe any signs and symptoms of choking, provide assisted devices with meals, obtain weights as ordered, speech therapy screen as need, and weekly weights. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/04/25, revealed that Resident #52 was severely cognitively impaired and required partial to moderate assistance meal assistance. Review of progress note dated 02/01/25 at 6:40 P.M. by unknown nurse stated another resident notified this nurse that the resident was choking. The nurse and another nurse ran to Resident #52 and noted her unable to make any noise, no coughing, no talking, and showing signs and symptoms of choking. Both nurses initiated the Heimlich Maneuver to Resident #52. Resident #52 coughed up the food and was able to speak. 911 arrived but did not take Resident #52 because she was responsive. Review of progress note dated 02/01/25 at 7:01 P.M. by unknown nurse stated Resident #52 was assessed and vitals as follows: blood pressure 136/78, heart rate 78 beats per minute, oxygen saturation 97 percent, blood sugar was 111, and temperature was 97.8 degrees Fahrenheit. Resident #52 was assessed for pain. Resident #52 stated she had not had pain or hurting at any time in the last five days. Review of progress note 02/01/25 at 7:21 P.M. by unknown nurse stated she notified the on call physician of choking event. The physician gave orders to assess her vitals once a shift until seen by physician next week. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility incident document dated 02/01/25 revealed Resident #52 was choking on a food item in the dining room. Agency Licensed Practical Nurse (LPN) #330 and another nurse administered the Heimlich Maneuver to Resident #52, who was coughing. Resident #52 coughed up an item and began to speak. Resident #52 denied pain or discomfort. Resident #52 stated she was trying to eat a sweet cake. Resident #52 had vitals assessed, assessed for pain. LPN #330 helped Resident #52 change her clothes. Resident #52's diet was reviewed. Resident #52 was to eat meals in the dining room with assistance. There was an order for consultation with speech therapy. A respiratory assessment was completed and a new order for a chest X-ray. LPN #330 stated there were no signs and symptoms of respiratory distress. LPN #330 notified the Director of Nursing (DON), guardian, and medical director. Resident #52 refused to be taken to the hospital. The predisposing environmental factor that affected Resident #52 was crowding. No injuries observed post incident of choking. Review of physician order dated 02/03/25 revealed Resident #52 had an order for a regular pureed diet with nectar thick liquids and a STAT chest X-ray for two views. Review of the facility chest X-ray result dated 02/03/25 revealed that Resident #52 had a chest x-ray impression that stated with comparison study from prior chest -ray done on date 10/28/24, Resident #52 had right basilar infiltrate developed since last X-ray. Review of physician order dated 02/05/25 revealed Resident #52 had an upgraded diet to mechanical textures, regular diet, nectar thick liquids, with ordered staff supervision during meals. Review of physician order dated 02/05/25 revealed Resident #52 was to have a speech evaluation. Review of physician order dated 02/17/25 revealed Resident #52 to have consistent carbohydrate diet, pureed texture, and nectar thick liquids. During an interview on 03/24/25 at 11:48 A.M., the Director of Nursing (DON) stated Resident #52 was aware she was on an altered diet. She took the corn bread from the resident sitting next to her. Resident #52 asked Nurse Supervisor (NS) #202 to open the corn bread, which was wrapped. NS #202 educated Resident #52 her diet, that she was a puree diet and could not have the corn bread. Resident #52 then found another piece of corn bread from another resident's food plate and asked Agency LPN #330 to open it for her. LPN #330 opened for Resident #30 and gave it to her without checking her diet. DON stated that Resident #52 ate it, and she began to choke. Nurse Supervisor (NS) #202 and LPN #330 performed the Heimlich maneuver on Resident #52. The emergency medical service arrived, and Resident #52 refused to be evaluated at the hospital. Resident #52's guardian was told she refused, and the guardian was ok with the resident's refusal to go out to the hospital. The DON stated Resident #52 was noncompliant in her diet and had since made her a one on one with all her meals. At this time, Resident #52 was compliant with the one-on-one staff at meals. During an interview on 03/25/25 at 5:50 P.M., LPN #330 stated she did give Resident #52 corn bread and did not look up or ask what Resident #52's diet was. Ten minutes later Resident #30 was in her wheelchair choking. LPN #330 tried to give her Heimlich, then another nurse assisted to help and the choking was resolved. LPN #52 stated she had never taken care of Resident #52 before and should have looked up her diet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility document titled Dietary Supervision of Resident's Nutrition, undated, revealed the facility personnel are responsible for assuring the Residents' are served the correct food tray. Prior to serving the food tray, the nurse aid must check the diet card to assure that the correct food tray was being served to the Resident. If there was doubt, the nurse supervisor or charge nurse will check the written physician's order. If an error has been made, report it to the dietary supervisor so that a new food tray can be issued. Residents needing assistance in eating must be promptly assisted upon being served. Self-help devices must be provided to those who need this assistance. The food and fluid intake must be observed by nursing personnel at each meal. The amount eaten must be recorded and or reported to the charge nurse. Deviations from the normal patterns must be recorded in the Resident's chart. The Director of Nursing and the Dietary Manager, with input from the consultant dietician, must review the Resident's nutritional problem and coordinate all resolutions. Recommendations must be presented to the attending physician for his or her approval. This deficiency represents non-compliance investigated under Complaint Number OH00162245.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on record review, observations, interview, and policy review, the facility failed to implement fall prevention interventions for residents. This affected one (Resident #46) of three residents reviewed for falls. The facility census was 55. Findings include: Record review revealed Resident #46 was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease, Schizophrenia disorder, disturbance psychotic disorder, anxiety disorder, irritable bowel syndrome, dementia, and pseudobulbar affect. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/18/24, revealed that Resident #46 was cognitively impaired. Resident #46 required maximal assistance for meals, oral care, personal hygiene, and dressing upper body. Resident #46 was dependent for dressing lower body, bathing, placing shoes on and off, and toileting hygiene. Review of the plan of care dated 02/07/25 revealed Resident #46 was at risk for falls related to Alzheimer's disease, impaired gait balance, impaired vision, schizophrenia, and seizure disorder. Interventions included floor mat placed to open side of bed while bed was occupied, close supervision by staff, encourage residents to lie down after lunch, fall risk assessment, ensure resident was wearing nonskid footwear, and left side of bed against the wall. Review of non-compliance that was resistant to assistance with care revealed that Resident #46 interventions was encouraged to keep call light in reach and encouraged to use assistance. During an observation on 03/24/25 at 3:54 P.M., Resident #46 was in bed, and had no call light in reach. Resident #46's call light was under the bed, at the wall. Resident #46 did not have his bedside table near him with personal items. There was no floor mat next to the bed. During an interview on 03/24/25 at 3:58 P.M., Nurse Supervisor (NS) #202 verified that Resident #46's call light was out of reach, that his personal items were out of reach and no fall mat was next to the bed. Review of facility document titled Call Light Policy and Procedure dated 12/2020 revealed the policy of the facility was to ensure timely response to resident call light to ensure needs are met. The call light was used by a resident to notify staff of the nursing facility that the resident had a need that he would like addressed. Staff will ensure that the resident was in a comfortable position and that the call light was within reach of the resident before leaving the resident's room. This deficiency represents non-compliance investigated under Complaint Number OH00163300.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44080 Based on observations, staff interview, and review of facility policy, the facility failed to provide clean, sanitary kitchen. This had the potential to affect all 55 residents residing in the facility who receive food from the kitchen. Findings include: During an observations of the kitchen on 03/25/25 at 11:08 A.M., the floor was dirty with food crumbs scattered on floor, cracks on the floor, dirt was smeared all over the floor, the trash can which was full of trash had no lid. A hair net was lying on the floor next to the trash can. There was a dirty bath blanket and four towels with black unknown substance on them in a pile under the kitchen sink next to prep table. Interview on 03/25/25 at 11:30 A.M. with [NAME] #134 verified there was a blanket and towels under the sink. [NAME] #234 stated there was a big accident in the kitchen and there was spillage on the floor. Review of the policy titled Dietary Food Preparation Area, undated, revealed the facility will maintain a clean, sanitary and safe food preparation area. The facility was to have a sink hot water and soap disposable, hand towel rack, and step-on trash can. This deficiency represents non-compliance investigated under Complaint Number OH00162245.