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	07/01/2025

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 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide information about how to apply for and use Medicare and Medicaid benefits. Based on medical record review, staff interview, resident interview, and review of the facility policy, the facility failed to provide residents with information regarding how to apply for Medicaid benefits. This affected one (Resident #53) of two residents reviewed for discharge. The facility census was 53. Findings include: Review of the medical record for Resident #53 revealed an admission date of 11/20/24 with diagnoses including chronic respiratory failure with hypoxia, severe protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), opioid dependence, cocaine abuse, pulmonary hypertension, bipolar disorder and post-traumatic stress disorder and a discharge date of 04/02/25. Review of a notice of adverse determination from the Medicaid provider for Resident #53 dated 03/28/25 revealed the resident no longer needed daily nursing care and her care needs could be met in a lower level of care. The document also included information for the resident with the opportunity to file a grievance against the decision or appeal the decision. Review of a social services progress note for Resident #53 dated 04/01/25 at 2:34 P.M. and created 04/02/25 at 2:38 P.M. per Social Services Director (SSD) #343 revealed she and the Director of Nursing (DON) spoke with Resident #53 about immediate discharge due to non-payment. The resident was in her room packing saying she would be discharging with her brother. This note was struck out on 04/08/25 with the reason cited as inaccurate documentation. Review of the Minimum Data Set (MDS) assessment for Resident #53 dated 04/02/25 revealed the resident had intact cognition and had an unplanned discharge Interview on 06/30/25 at 10:08 A.M. with Business Office Manager (BOM) #450 confirmed Resident #53 had a skilled care Medicaid payor and payment was stopped because the resident no longer required a skilled nursing service. The BOM verified the facility had the opportunity to assist the resident in applying for long-term Medicaid services but did not do so. She had no explanation as to why the facility did not do so. Follow up interview on 06/30/25 at 10:51 A.M. with BOM #450 verified the facility did not provide Resident #53 the opportunity or assistance to apply for long-term Medicaid. Phone interview on 06/30/25 at 3:00 P.M. with Resident #53 verified she was not offered the opportunity or assistance to apply for long-term Medicaid. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Transfer and discharge date d 10/17/22 revealed a facility-initiated transfer or discharge was a transfer or discharge to which the resident objects or did not originate through a resident's verbal or written request, and/or was not in alignment with the resident's stated goals for care and preferences. The facility would not initiate the discharge of a resident based solely on resident's payment source or change in the resident's payment source. If the resident continued to need long-term care services, the facility would offer the resident the ability to remain in the facility by providing the Medicaid-eligible residents with the necessary assistance to apply for Medicaid coverage. This deficiency represents noncompliance investigated under Complaint Number OH00164494.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on medical record review, staff interview, resident interview, and review of the facility policy, the facility failed to ensure a safe and orderly discharge. The affected one (Resident #53) of two residents reviewed for discharge. The facility census was 53 residents. Findings include: Review of the medical record for Resident #53 revealed an admission date of 11/20/24 with diagnoses including chronic respiratory failure with hypoxia, severe protein-calorie malnutrition, chronic obstructive pulmonary disease, opioid dependence, cocaine abuse, pulmonary hypertension, bipolar disorder and post-traumatic stress disorder. The resident was discharged from the facility on 04/02/25. Review of the physician's orders for Resident #53 revealed an order dated 01/27/25 for oxygen at three liters per minute via nasal cannula every shift. Review of a notice of adverse determination from the Medicaid provider for Resident #53 dated 03/28/25 revealed the resident no longer needed daily nursing care and that her care needs could be met at a lower level of care. The document also provided the resident with the opportunity to file a grievance against the decision or appeal the decision. Review of a social services progress note for Resident #53 dated 04/01/25 at 2:34 P.M. and created 04/02/25 at 2:38 P.M. per Social Services Director (SSD) #343 revealed she and the Director of Nursing (DON) spoke with Resident #53 about immediate discharge due to non-payment. The resident was in her room packing saying she would be discharging with her brother. This note was struck out on 04/08/25 with the reason cited as inaccurate documentation. Review of the Minimum Data Set (MDS) assessment for Resident #53 dated 04/02/25 revealed the resident had an unplanned discharge. Resident #53 had intact cognition, was always continent of bowel and bladder was independent for eating, required supervision for oral and personal hygiene, bed mobility and toileting, and required moderate assistance for bathing, dressing and transfers. Interview on 06/30/25 at 10:14 A.M. with SSD #343 confirmed Resident #53 was discharged to the community without home health and oxygen services in place and the exact location of the discharge was unknown. Interview on 06/30/25 at 10:27 A.M. with the DON confirmed she was involved in the discharge of Resident #53 and the resident was not offered the opportunity to appeal the noncoverage of services decision. The DON confirmed the facility had not made arrangements for home health or oxygen services for Resident #53 prior to discharge and these services should have been arranged at the time of discharge. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 06/30/25 at 3:00 P.M. with Resident #53 confirmed the SSD and the DON told her she had to leave the facility because Medicaid stopped paying. Resident #53 confirmed the facility staff told her she had 12 hours to leave, or they would call the police. Resident #53 confirmed the facility did not offer home health services or ongoing oxygen services. Resident #53 confirmed the facility discharged her with a four-hour oxygen tank and she had to take the oxygen nasal cannula she used while at the facility to receive the oxygen from the tank. Resident #53 confirmed after the oxygen tank ran out, she went to the hospital and remained there for 24 hours. After the hospitalization Resident #53 confirmed she was living on the street. Resident #53 confirmed she was currently staying with her mother and was trying to be admitted to a local homeless shelter. Phone interview on 06/30/25 at 4:30 P.M. with the Ombudsman confirmed there was a meeting with Resident #53 at the hospital discussing the resident's discharge. The Ombudsman confirmed Resident #53 did not want to remain a resident of the facility long-term, but the facility did not make the proper arrangements needed for a safe discharge such as a safe destination and provision of home health and oxygen services. Phone interview on 07/01/25 at 10:13 A.M. with Medical Director (MD) #405 for Resident #53 confirmed she was not involved in Resident 53's discharge and had no knowledge of where the resident's discharge location. MD #405 confirmed Resident #53 needed continuous oxygen due to her compromised respiratory status and should never have been discharged without home health services and an adequate supply of oxygen and oxygen supplies. Review of the facility policy titled Transfer and discharge date d 10/17/22 revealed a facility-initiated transfer or discharge was a transfer or discharge to which the resident objects or which did not originate through a resident's verbal or written request and/or was not in alignment with the resident's stated goals for care and preferences. Orientation for transfer or discharge would be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident could understand. Depending on the circumstances, the orientation might be provided by various members of the interdisciplinary team. This deficiency represents noncompliance investigated under Complaint Number OH00164494.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, resident interview, and review of the facility policy, the facility provide an accurate notice of discharge to a resident before discharge and failed to provide a copy of the discharge notice to the Ombudsman. This affected one (Resident #53) of two residents reviewed for discharge. The facility census was 53 residents. Findings include: Review of the medical record for Resident #53 revealed an admission date of 11/20/24 with diagnoses including chronic respiratory failure with hypoxia, severe protein-calorie malnutrition, chronic obstructive pulmonary disease, opioid dependence, cocaine abuse, pulmonary hypertension, bipolar disorder and post-traumatic stress disorder. The resident was discharged from the facility on 04/02/25. Review of the Minimum Data Set (MDS) assessment for Resident #53 dated 04/02/25 revealed the resident had an unplanned discharge. Resident #53 had intact cognition, was always continent of bowel and bladder was independent for eating, required supervision for oral and personal hygiene, bed mobility and toileting, and required moderate assistance for bathing, dressing and transfers. Review of the medical record for Resident #53 revealed the record did not include information regarding a formal discharge from the facility and there was no documentation per the physician regarding the resident's discharge. Interview on 06/30/25 at 10:27 A.M. with the Director of Nursing (DON) confirmed Resident #53 was discharged from the facility to the community on 04/02/25, and the facility did not provide the resident with a written discharge notice. Interview on 06/30/25 at 10:39 A.M. with Social Services Director (SSD) #343 confirmed Resident #53 was discharged to the community on 04/02/25 without home health and oxygen services in place and the exact location of the discharge was unknown. SSD #343 verified Resident #53 was not provided with a thirty-day discharge notice. Phone interview on 06/30/25 at 3:00 P.M. with Resident #53 confirmed the SSD and the DON told her she had to leave the facility because Medicaid stopped paying. Resident #53 confirmed the facility staff told her she had 12 hours to leave, or the police would be called. The resident said the facility did not offer her the opportunity to appeal the decision, and she did not learn about the appeal process until she met with the Ombudsman at the hospital on [DATE]. Resident #53 confirmed the facility did not issue her a written discharge notice. Phone interview on 06/30/25 at 4:30 P.M. with the Ombudsman confirmed there was a meeting with Resident #53 at the hospital discussing the resident's discharge and the facility did not provide a notice of the resident's discharge to the Ombudsman's office. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 07/01/25 at 10:13 A.M. with Medical Director (MD) #405 confirmed she was not involved with the facility's decision to discharge Resident #53 and had no knowledge of the resident's discharge location. MD #405 confirmed did not sign a written discharge notice nor did she document in the resident's medical record regarding the discharge. Review of the policy titled Transfer and discharge date d 10/17/22 revealed the facility's transfer/discharge notice would be provided to the resident and the resident's representative in a language and manner in which the resident could understand. Generally, the notice must be provided at least 30 days prior to a facility-initiated transfer or discharge of the resident. Exceptions to the 30-day requirement applied when the transfer or discharge was affected because the health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident, resident's health improved sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge was required by the resident's urgent medical needs, or the resident had not resided in the facility for 30 days. A written discharge notice must be provided to the resident, resident's representative if appropriate, and the Ombudsman as soon as practicable before the transfer or discharge. The facility would maintain evidence that the notice was sent to the Ombudsman. This deficiency represents noncompliance investigated under Complaint Number OH00164494.