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	12/11/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review the facility failed to thoroughly investigate an allegation of abuse. This affected one (Resident #21) of three residents reviewed for abuse. The facility census was 40.Medical record review for Resident #19 revealed she was admitted to the facility on [DATE]. Diagnoses included anxiety disorder, seizure, malignant neoplasm of the intrathoracic lymph node, delusional disorder, atrial fibrillation, essential primary hypertension, and multiple sclerosis.Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #19 had impaired cognition. Resident #19 was dependent on staff for activities of daily living (ADL).Review of the SRI (control number 266147) created on 10/08/25 at 1:41 P.M. related to an injury of unknown origin identified on 10/08/25. Resident #19 alleged Licensed Practical Nurse (LPN) #97 grabbed her arms during a disagreement and left discoloration. The facility collected statements from LPN #97 and Resident #19. The SRI indicated LPN #97 was providing personal care to Resident #19 who was upset with her sister at the time of personal care. LPN #97 attempted to change Resident #19's brief and moved the call light from underneath Resident #19, when the resident became angry and grabbed the call light. After Resident #19 grabbed the call light, it swung and hit the resident in the arm and the refrigerator near the bed. LPN #97 stated she saw the call light hit Resident #19's arm which could have caused the discoloration on the arm. The facility closed the investigation on 10/08/25 at 2:12 P.M. and unsubstantiated the allegation of abuse. Review of the October 2025 progress notes for Resident #19 revealed no documented information related to the allegations of abuse.Review of the facility investigation on 12/11/25 at 1:115 P.M., revealed one witness statement collected from LPN #97. No other information was documented in the facility investigation.Interview on 12/11/25 at 1:30 P.M. the Administrator confirmed the facility failed to complete a thorough investigation related to abuse allegations involving Resident #19 and LPN #97. The Administrator stated he would have expected the facility staff to complete a thorough investigation. Review of the facility policy titled Abuse Neglect and Exploitation dated 2025 revealed an immediate investigation was warranted when suspicion of abuse, neglect, or exploitation or reports of abuse occur. The facility was expected to interview all involved people, including the alleged victim, alleged perpetrator, and others who may have knowledge of the alleged incident. The facility would complete a thorough investigation including all documentation of the investigation.

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 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** Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to provide a safe environment related to residents smoking. This affected one (Resident #36) of the one resident observed for smoking. The facility census was 40.Findings include:Medical record review for Resident #36 revealed he was admitted to the facility on [DATE]. Diagnoses included nontraumatic intracerebral hemorrhage, dysphagia, essential primary hypertension, major depressive disorder, hyperlipidemia, congestive heart failure, and diabetes mellitus (DM).Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was cognitively intact. Resident #36 was dependent on staff for medication administration. Resident #36 required set up assistance from staff with eating, oral hygiene, toilet use, and supervision with bathing. He was independent with upper body dressing, lower body dressing, and personal hygiene.Review of the active care plan for Resident #36 revealed the resident was a supervised smoker. The interventions included Resident #36 was a supervised smoker in a designated smoking areas and smoking materials were to be stored in a designated area.Review of the smoking assessment for Resident #36 dated 11/11/25 revealed Resident #36 was listed as an independent smoker. Observation on 12/10/25 at 9:25 A.M. revealed Resident #36 was smoking while seated in his wheelchair inside the facility but in the doorway which exited to the courtyard. Resident #36 acknowledged he was smoking unsupervised inside the facility. Resident #36 would not say how he was able to obtain a cigarette and lighter. Interview on 12/10/25 at 9:26 A.M. MDS Nurse #77 verified Resident #36 was smoking inside the facility and in the doorway which led to the courtyard. MDS #77 confirmed the facility had designated smoking times and it was not a designated smoking time. MDS #77 verified the facility does not allow independent or dependent smokers to keep smoking items and could not say how Resident #36 had access to his smoking items. MDS #77 stated Resident #26 was non-compliant with following smoking rules. Interview with the Director of Nursing (DON) on 12/10/25 at 9:44 A.M. stated the Courtyard was designated smoking area and there were scheduled smoking times. The DON stated all smoking items were supposed to be kept at the nurse's station and the staff were to assist all smokers. The DON verified Residents should be outside of the facility when smoking and supervised by staff.Review of the facility smoking policy titled Resident Smoking dated 2025 confirmed the facility would provide a safe and healthy environment for residents, visitors, and employees, including safety related to smoking. Smoking was prohibited in all areas except the resident's designated smoking area. Signage identifying the designated smoking area will be prominently displayed. Safety measures for designated smoking areas would include protection from weather conditions, provision of ash trays, and located the required distance, at a minimum from public exits and common space.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, resident interview, record review, and facility policy review, the facility failed to maintain mechanical equipment to heat residents' rooms. This affected four Residents (#33, #34, #35, and #36) out of four Residents reviewed. The facility census was 40. Findings include:Medical record review for Resident #34 revealed he was admitted to the facility on [DATE]. Diagnoses included quadriplegia, chronic obstructive pulmonary disease (COPD), essential primary hypertension, gastro-esophageal reflux disease (GERD), hyperlipidemia, insomnia, major depressive disorder, diabetes mellitus (DM), and anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #34 dated 11/20/25, revealed he was cognitively intact.Medical record review for Resident #35 revealed he was admitted to the facility on [DATE]. Diagnoses included essential primary hypertension, asthma, intermittent explosive disorder, heart failure, anemia, major depressive disorder, generalized anxiety disorder, COPD, GERD, and morbid obesity.Review of the MDS assessment dated [DATE] for Resident #35 revealed he was cognitively intact.Observation on 12/11/25 at 9:49 A.M. revealed Resident #34 was seated in the hallway with a blanket on his head and shoulders. Resident #24 appeared to be shivering under the blanket.Interview with Resident #34 at the same time stated he was seated in the hallway with a blanket on his head and shoulders because his room was freezing. Resident #34 stated he was in the hallway because he was trying to get warm. Resident #34 stated no staff member asked him if he wanted to change rooms. Observation on 12/11/25 at 9:51 A.M. revealed Resident #35 could be heard yelling into the hallway from his room that he was cold and needed someone to fix his heat. Interview with Resident #35 at the same time revealed he was in his room yelling out the doorway that he was cold and needed someone to fix the heat in his room. Resident #35 stated he was aware of the heat not working in his room and denied being asked by staff if he wanted to move to another room.Interview on 12/11/25 at 9:55 A.M. Maintenance Supervisor (MS) #150 verified Residents' #33, #34, #35, and #36's room did not have any heat. MS #150 confirmed the heat had not worked in Residents' #33, #34, #35, and #36's room for several months. MS #150 stated he was not aware of any documentation where Residents' #33, #34, #35 and #36 were asked to move rooms because the heat was not working in their rooms. Observation revealed MS #150 obtained the following temperatures from the four rooms: Resident #33's room temperature was 66.5 degrees Fahrenheit (F), Resident #34's room temperature was 69.7 degrees F, Resident #35's room temperature was 67.7 degrees F, and Resident #36's room temperature was 68.4 degrees F. MS #150 stated room [ROOM NUMBER] did not have a current resident; however, the room does not have heat and the temperature was 64.8 degrees F. MS #150 confirmed he had obtained two quotes to have the heating system replaced. One was dated 10/30/25, and the other was dated 11/11/25. MS #150 stated the reason the replacement unit took so long was for corporate approval.Review of the facility policy titled Safe and Homelike Environment dated 2023 confirmed the facility will provide a safe, clean, comfortable, and homelike environment. Maintenance services will provide as necessary to maintain a comfortable environment. The facility will maintain comfortable and safe temperature levels. The facility should strive to keep room temperatures between 71 degrees F and 81 degrees F.Review of the facility policy titled Resident Rights dated 2024 confirmed the Residents have the right to a safe, clean, comfortable, and homelike environment.This deficiency represents non-compliance investigated under Master Complaint Number 2687930.