

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Bradford Place Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Millville Avenue Hamilton, OH 45013	
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 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on record review, observations, staff interviews, and policy review, the facility failed to ensure Resident #19 received prompt dental care services. This resulted in Actual Harm when Resident #19, who had persistent dental pain, developed a dental infection and had significant weight loss. On 06/19/25 at 6:50 P.M., Resident #19, who was nonverbal, screamed loudly for most of the shift due to dental pain and was unable to be redirected. On 06/20/25, Resident #19 ' s oral intake decreased related to ongoing dental pain. Resident #19 was seen by the nursing staff on 06/25/25 for continued behaviors including a decrease in oral intake, biting on her fingers, and was suspected of having a dental infection. Resident #19 was started on Augmentin, an antibiotic, related to a tooth infection. On 07/07/25, Resident #19 continued to have behaviors and had lost weight due to not eating related to dental pain. On 07/15/25, Resident #19 continued to have documented weight loss from decreased oral intake related to dental pain and a dental consultation was ordered. The consult was not scheduled until 10/03/25. This affected one (Resident #19) of one resident reviewed for dental services. The facility census was 75. Findings include:Review of the medical record for Resident #19 revealed an admission date of 03/14/24. Diagnoses included vascular dementia, type II diabetes mellitus (DM II), major depressive disorder, and epilepsy. Review of the physician order dated 12/19/24, revealed Resident #19 was ordered Tylenol 325 milligrams (mg), two tablets every six hours as needed (PRN) for pain or fever.Review of the Significant Change Minimum Data Set (MDS) assessment for Resident #19 dated 07/23/25, revealed the resident had severe cognitive impairment. Resident #19 required assistance with activities of daily living (ADL). Resident#19 had a five percent weight loss or more in the last month and received a feeding tube and a mechanically altered diet.Review of the progress note dated 06/19/25 at 6:50 P.M., revealed Resident #19 spent most of the shift screaming loudly while in the common area. Redirection was attempted but was unsuccessful. Review of the meal intakes for Resident #19 dated 06/20/25, revealed the resident ate 26 to 50 percent of meals. On 06/21/25 and 06/22/25, Resident #19 ' s meal intakes were zero to 25 percent. Starting on 06/26/25 through 08/04/25, the resident refused meals or averaged less than 50 percent for oral intakes. Prior to this, her intakes were 100 percent.Review of the progress note dated 06/25/25 at 11:53 P.M., revealed Resident #19 was seen for continued behaviors, and per the staff, she was not eating and appeared to be biting her fingers. At times, the resident refused her medications by spitting them out. The resident was started on Augmentin for a presumed tooth infection. Resident #19 was nonverbal and it was hard to obtain information about how she was feeling and if she continued to refuse medications, the resident would need to consult with general surgery for gastric tube (g-tube) placement. Review of the physician order dated 06/25/25, revealed Resident #19 was ordered Augmentin 500-125 mg, twice daily for seven days for a tooth infection.Review of the June 2025 Medication Administration Record (MAR) for Resident #19 revealed she was not administered any Tylenol related to dental pain.Review of the progress note dated 07/07/25 at 3:11 P.M., revealed Resident #19 triggered for a weight review due to a weight loss of five percent in the last 30 days. Resident #19 was unable to communicate well, so the weight loss was discussed with nursing, who reported the resident had not been eating for three weeks from behaviors related to tooth pain. Three weeks ago, Resident #19 was eating 100 percent of her meals (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 0791 Level of Harm - Actual harm Residents Affected - Few	dental pain.Review of the facility policy titled Dental Services for Residents, dated 10/02/23, revealed the facility would ensure that all residents received appropriate access to routine and emergency dental services. The facility shall ensure access to 24-hour emergency dental care for all residents. The staff must respond promptly to dental emergencies and coordinate care with external provided as needed.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure food was served in an appetizing manner. This affected two (Residents #86 and #16) and had the potential to affect all of the residents residing in the facility. The facility census was 75 residents. Findings include: Observation on 09/23/25 at 12:15 P.M. of a test tray revealed there were two tacos wrapped in foil with liquid pooled up underneath the plate. There was a significant amount of liquid contained within the foil and the tortilla of the taco was saturated with liquid. Interview on 09/23/25 at 12:16 P.M. with District Manager (DM) #600 verified there was liquid in the foil which altered the texture of the tortillas. Observation on 09/23/25 at 12:25 P.M. revealed Resident #86 attempted to eat the tacos on his lunch tray. The tortillas were wet and soggy and the resident had difficulty eating the tacos. Interview on 09/23/25 on 12:26 P.M. with Resident #86 confirmed the taco tortillas were wet and soggy and he could not eat them. Interview on 09/23/25 at 3:24 P.M. with Resident #16 confirmed the tacos he received at lunch were greasy and there was liquid inside the foil pouch containing the tacos. Resident #16 further stated he had to take his napkin to dry off the taco because it was soaked with liquid and then another part of the tortilla was too hard for him to chew. Review of the facility policy titled Food: Quality and Palatability dated February 2023 revealed food would be prepared by methods that conserved the nutritive value, flavor, and appearance. Food should be palatable and attractive. This deficiency represents noncompliance investigated under Complaint Number 1335090.		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure beverage preferences and requests were honored. This affected one (Resident #16) of one residents reviewed for food preferences and had the potential to affect all of the residents residing in the facility. The facility census was 75 residents. Findings include: Observation on 09/22/25 at 11:46 A.M. revealed Certified Nursing Assistant (CNA) #525 entered Resident #16's room to deliver a lunch tray. Resident #16 asked CNA #525 for milk. CNA #525 stated there was no milk in the refrigerator, but otherwise she would give it to him. Interview on 09/22/25 at 11:47 A.M. with CNA #525 verified Resident #16 asked for milk and she told him it was not available. CNA #525 confirmed she did not go look for the milk or call the kitchen for the milk and further stated if the resident was supposed to have it, it would have been on his tray. Interview on 09/23/25 at 3:24 P.M. with Resident #16 verified he did not get the milk he requested at lunch the day prior. Resident #16 stated he requested milk daily and usually did not receive the milk as requested. Review of the facility policy titled Dining and Food Preferences dated October 2022 revealed, during meal service residents who requested an alternate beverage selection would be provided with the selection in a timely manner.		

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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. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure food was prepared, served and stored in a manner to protect against the potential spread of foodborne illness. This affected one (Resident #10) and had the potential to affect all of the residents residing in the facility. The facility census was 75 residents. Findings include: Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure food was prepared, served and stored in a manner to protect against the potential spread of foodborne illness. This affected one (Resident #10) and had the potential to affect all of the residents residing in the facility. The facility census was 75 residents. Findings include: 1. Observation on 09/23/25 at 11:50 A.M. revealed [NAME] #701 prepared trays for the lunch meal on tray line. [NAME] #701 placed a scoop of cooked peppers and onions onto a plate. [NAME] #701 used his bare fingers to pick up a piece of onion which was hanging over the edge of the plate to reposition the onion back onto the plate. Interview on 09/23/25 at 11:51 A.M. with [NAME] #701 verified he picked up the piece of onion with his bare hand and repositioned it back on the plate. Interview on 09/23/25 at 11:52 A.M. with Food Service Manager (FSM) #700 verified [NAME] #701 handled the food with his bare hands and staff should never use their bare hands to handle food directly. 2. Observation on 09/24/25 at 10:41 A.M. revealed [NAME] #701 placed sliced bread on a pan using his bare hands. Interview on 09/24/25 at 10:42 A.M. with [NAME] #701 verified he had handled the bread with his bare hands. Interview on 09/24/25 at 10:43 A.M. with District Manager (DM) #600 verified staff should never handle food with their bare hands. Review of the facility policy titled Food Preparation dated February 2025 revealed all staff would practice proper glove use and all staff would use serving utensils appropriately to prevent cross contamination. 3. Review of the medical record for Resident # 10 revealed an admission date of 03/09/23 with diagnoses including paraplegia, osteomyelitis of vertebra, protein malnutrition, neuromuscular dysfunction of bladder, and injury of lumbar spinal cord. Review of the Minimum Data Set, (MDS) assessment for Resident #10 dated 09/16/25 revealed the resident had intact cognition and required set up with activities of daily living (ADLs.) Review of the meal ticket for Resident #10 revealed he received two boiled eggs on each breakfast and lunch meal tray. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 09/22/25 at 1:48 P.M. revealed there were nine insulated bowls stacked on Resident #10's dresser. The bowls were dated from 09/16/25 to 09/20/25 and contained one boiled egg. Observation on 09/24/25 at 8:45 A.M. revealed there was one insulated bowl on the hallway railing outside Resident #10's room dated 09/22/25 containing one boiled egg. Observation on 09/24/25 at 1:00 P.M. revealed there were five insulated bowls stacked in the Resident #10's dresser dated 09/20/25 to 09/22/25 containing one boiled egg. Observation on 09/24/25 at 4:00 P.M. revealed Resident #10 finished his lunch meal and asked CNA #504 to remove his lunch meal from his room. Interview on 09/22/25 at 9:30 A.M. with Resident #10 confirmed he received boiled eggs on his breakfast and lunch meal trays. Resident #10 stated he never eats breakfast because he sleeps till noon. Resident #10 stated he had the aides put his bowls of boiled eggs from the breakfast meal on his dresser in case he wanted to eat the eggs in the afternoon or the next day. Resident #10 stated the nine bowls of eggs currently on his dresser were from one to two days ago. Resident #10 further stated he does not eat lunch until around 4:00 P.M. and received the lunch meal on 09/22/25 at around noon. The aides did not remove the meal tray from lunch until after 4:00 P.M. Resident #10 stated he received the dinner meal around 5:00 P.M. but did not consume the meal until after 8:00 P.M. Resident #10 confirmed staff did not refrigerate his meal trays when he didn't eat them right away. Resident #10 stated he might consume the boiled eggs from atop his dresser throughout the night. Interview on 09/24/25 at 8:45 A.M. with Certified Nursing Assistant CNA #504 verified there was bowl of boiled eggs on the handrail outside of Resident #10's room saved from his breakfast tray. CNA #504 verified there were five stacked bowls containing boiled eggs on the resident's dresser dated 09/20/25 through 09/22/25. CNA #504 stated she had not refrigerated Resident #10 bowls of boiled eggs and stated she did not know how long boiled eggs could be safely unrefrigerated Interview on 09/24/25 at 4:02 P.M. with Resident #10 verified the aides had delivered his lunch tray around noon but he did not consume the meal until 4:00 P.M. after which he asked Certified Nursing Assistant (CNA) #504 to remove the lunch meal tray at 4:00 P.M. Interview on 09/24/25 at 12:30 P.M with DM #700 verified Resident #10 received boiled eggs in insulated bowls at breakfast and lunch. DM #700 stated perishable food stored like boiled eggs could only be stored unrefrigerated safely in insulated bowls no longer than two hours and stored refrigerated up to five days. She stated a meal tray should be consumed by a resident and could be stored refrigerated no longer than one hour after delivery. DM #700 verified there was a refrigerator designated for resident food storage available on the unit. Interview on 09/25/25 at 12:10 P.M. with Registered Dietitian (RD) # 605 verified when Resident #10 chose not to eat a meal when delivered, the meal should be refrigerated by the staff and reheated upon the residents' request. Eggs should not be left unrefrigerated for more than two hours. Review of the facility policy Food Preparation dated February 2025 revealed eggs will be cooled to 70 degrees Fahrenheit within two hours of cooking.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the Resident Council meeting minutes, the facility failed to respond and address resident concerns expressed in the Resident Council meetings. This affected five (#56, #14, #44, #39 and #67) of the five residents interviewed during Resident Council meeting. The facility total census was 75. Findings included: Record Review of Resident #56 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #56 include anemia. Review of the Minimum Data Set (MDS) comprehensive assessment for Resident #56 dated 07/02/25, revealed the resident had intact cognition. Record review of Resident #14 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #14 Alzheimer's disease. Review of the MDS comprehensive assessment for Resident #14 dated 09/10/25, revealed the resident had moderately impaired cognition. Record review of Resident #44 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #44 include heart failure. Review of the MDS comprehensive assessment for Resident #44 dated 07/08/25 revealed the resident had moderately impaired cognition. Record review of Resident #39 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #39 include chronic obstructive pulmonary disease. Review of the MDS comprehensive assessment for Resident #39 dated 08/18/25, revealed the resident had moderately impaired cognition. Record review of Resident #67 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #67 include interstitial pulmonary disease. Review of the MDS comprehensive assessment dated [DATE] revealed the resident had intact cognition. Review of the Resident Council Meetings minutes for 03/19/25, 04/29/25, 05/28/25, 06/25/25, 07/30/25, and 08/28/25 on 09/23/25 at 9:20 A.M., revealed the following: Food concerns for five out of the six months, nursing care concerns for four out of the six months, housekeeping services concerns for four out of the six months, and maintenance service concerns for two out of the six months reviewed. There were no documented notes in the meeting minutes regarding the previous month's resolutions addressing the residents' concerns. Interview on 09/23/25 at 9:30 A.M., Activity Director, (AD) #175 who stated he led the Resident Council monthly meetings. AD #175 stated he did not have any documented evidence where he discussed the resolutions of the residents' previous months' concerns or had evidence that the concerns had been acted upon by the food service, nursing service housekeeping service or and maintenance service departments. AD #275 stated the residents should have resolution feedback regarding their concerns during Resident Council meetings. Interview with Residents #56, #14, #44, #39 and #67 on 09/24/25 at 1:30 P.M. who stated they regularly attended the Resident Council meeting. The residents stated during the Resident Council Meetings held on 03/19/25, 04/29/25, 05/28/25, 06/25/25, 07/30/25, and 08/28/25, there were no discussions of resolutions to their concerns voiced in the previous resident council meeting. The residents stated the same concerns were brought up during several meetings. There was no facility policy provided regarding Resident Council Meeting minutes. This deficiency represents non-compliance investigated under Complaint Number 1335090.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, care conference summary report review, care plan review, staff interview, and policy review, the facility failed to ensure care conferences were provided on a quarterly basis with the Resident and/or Representative and failed to ensure care plans were updated timely. This affected five (#30, #07, #06, #03, and #55) of the eight residents reviewed for care plans. The facility also failed to ensure care plans were updated timely when a change in condition occurred. This affected two (#19 and #45) of the eight residents reviewed for care plans. The facility census was 75. Findings included: 1) Review of the medical record revealed Resident #30 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure with hypoxia, chronic obstructive pulmonary diseases, congestive heart failure, hypertension, sleep apnea, and morbid obesity. Review of the Minimum Data Set (MDS) Medicare-Five Day assessment dated [DATE] revealed Resident #30 had intact cognition. Review of Care Conference Summary Reports for Resident #30 on 09/22/25 at 5:00 P.M., revealed the resident did not have a care conference conducted in the first quarter of 2025 (January, February and March). Interview on 09/22/25 at 5:03 P.M. with Social Service Director (SSD) #150, verified the facility failed to conduct a Care Conference for Resident #30 in the first quarter of 2025 (January, February, March). 2) Review of the medical record revealed Resident #07 was admitted to the facility on [DATE]. Diagnoses included end stage renal disease (ESRD) with dependent on hemodialysis, diabetes mellitus type II, and cerebral infarction that resulted in aphasia and hemiplegia (non-dominant left side). Review of the MDS quarterly assessment dated [DATE] revealed Resident #07 had intact cognition. Review of Care Conference Summary Reports for Resident #07 on 09/22/25 at 5:00 P.M., revealed the facility failed to conduct a care conference for Resident #07 in the second quarter of 2025 (April, May, June). Interview on 09/22/25 at 5:03 P.M. with SSD #150, verified the facility failed to conduct a Care Conference for Resident #07 in the second quarter of 2025 (April, May, June). 3) Review of the medical record revealed Resident #06 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), diabetes mellitus type II, and major depressive disorder. Review of the MDS Medicare Five-Day assessment dated [DATE], revealed Resident #06 had moderate cognitive impairment. Review of Care Conference Summary Reports for Resident #06 on 09/22/25 at 5:00 P.M., revealed the facility failed to conduct a care conference for Resident #06 in the first quarter of 2025 (January, February and March). Interview on 09/22/25 at 5:03 P.M. with SSD #150, verified the facility failed to conduct a Care Conference for Resident #06 in the first quarter of 2025. 4) Review of the medical record revealed Resident #03 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, obstructive hydrocephalus, diabetes mellitus type II, morbid obesity, hypertension and chronic kidney disease stage IV. Review of Care Conference Summary Reports for Resident #03 on 09/22/25 at 5:00 P.M., revealed the facility failed to conduct a care conference for Resident #07 in the second quarter of 2025 (April, May and June). Interview on 09/22/25 at 5:03 P.M. with SSD #150 verified the facility failed to conduct a Care Conference for Resident #03 in the second quarter of 2025 (April, May, June). 5) Review of the medical record for Resident #55 revealed an admission date of 06/07/23. Diagnoses included chronic obstructive pulmonary disease (COPD), acute and respiratory failure with hypoxia, and type II diabetes mellitus (DM II). Review of the Quarterly MDS assessment dated [DATE] revealed Resident #55 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 13. Review of the care conferences for Resident #55 revealed she had not had a care conference since 06/09/23. Interview on 09/24/2025 1:55 PM with SSD #150 verified Resident #55 had not had a care conference since 06/09/23. 6) Review of the medical record for Resident #19 revealed an admission date of 03/14/24. Diagnoses included vascular dementia, type II diabetes mellitus (DM II), major depressive disorder, and epilepsy. Review of the (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Significant Change MDS assessment dated [DATE] revealed Resident #19 had severe cognitive impairment as evidenced by a BIMS score of two. Section K (swallowing disorders) revealed the resident had a five percent weight loss or more in the last month and received feeding tube and a mechanically altered diet. Review of the Nutrition Care Plan for Resident #19, revealed the care plan was not updated after the significant weight loss occurred. Review of the weights for Resident #19 on 09/25/25 at 12:15 P.M., revealed a significant weight loss occurred from 06/22/25 at 142.4 pounds (lb.) to 07/06/25 at 134.2 lb. which equaled 8.2-pound loss or 5.76 percent (%) weight loss. Interview on 09/25/25 at 12:18 P.M. with Registered Dietician (RD) #605, verified she did not update the care plan after Resident #19 had a significant weight loss. 7) Review of the medical record of Resident #45 revealed an admission date of 02/16/23. Diagnoses included type 2 diabetes mellitus, depression, Alzheimer's disease with behavioral disturbance, depression, anxiety, hypertension. Review of Resident #45's weights revealed on 01/08/25, Resident #45 weighed 190.8 lb. On 02/01/25, Resident #45 weighed 191.2 lb. On 03/01/25, Resident #45 weighed 189.2 lb. On 04/12/25, Resident #45 weighed 190.4 lb. On 05/01/25, Resident #45 weighed 188.4 lb. On 06/02/25, Resident #45 weighed 187.6 lb. On 07/02/25, Resident #45 weighed 176.8 lb. On 08/01/25, Resident #45 weighed 172.6 lb. On 09/08/25, Resident #45 weighed 168.2 lb. Review of the plan of care dated 04/16/25 revealed Resident #45 was at nutritional risk related to diagnoses of type 2 diabetes mellitus-requiring a therapeutic diet, depression, hypertension, Alzheimer's disease, and a history of refusing medications. The care plan revealed no documented evidence of being updated relating to the resident's recent significant weight loss. Review of a Weight Note dated 07/03/25, revealed Resident #45 triggered for a weight loss of greater than 5 % for one month. The progress note revealed no documented evidence of the resident's responsible party and physician being notified. Review of the quarterly MDS assessment dated [DATE], revealed Resident #45 had severely impaired cognition. The resident weighed 177 lb. and had a significant non-prescribed weight loss. Review of a Weight Note dated 08/05/25, revealed Resident #45 triggered for a 9 % weight loss for three months. The progress note revealed no documented evidence of the resident's responsible party and physician being notified. Review of a Weight Note dated 09/09/25, revealed Resident #45 triggered for a weight loss of greater than 10 % for six months. The progress note revealed no documented evidence of the resident's responsible party and physician being notified. Interview on 09/25/25 at 12:33 P.M., RD #605 verified Resident #45's weight loss was not mentioned in the nutrition care plan. RD #605 verified the care plan should have been updated to reflect the recent weight loss. Review of policy titled, Care Planning-Interdisciplinary Team, revised March 2022, revealed the resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. Review of policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed the Interdisciplinary Team (IDT) reviews and updates the care plan at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) assessment. This deficiency represents non-compliance investigated under Complaint Number 1335090.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure medications were administered in a sanitary manner. This affected one (Resident #19) of four residents observed for medication administration. Based on medical record review, observation, and staff interview, the facility failed to follow physician ordered transmission-based precautions. This affected three (Residents #19, # 85, #81) of four residents reviewed for transmission-based precautions. Based on observation and staff interview, the facility also failed to ensure staff practiced appropriate hand hygiene during delivery of meal trays. This affected three (Residents #31, #65 and #86) and had the potential to affect all of the residents residing in the facility. The facility census was 75 residents. Findings include: 1. Review of the medical record for Resident #39 revealed an admission date of 07/19/22 with diagnoses including chronic obstructive pulmonary disease, atrial fibrillation, congestive heart failure and diabetes mellitus type two. Review of the Minimum Data Set (MDS) assessment for Resident #39 dated 08/18/25 revealed the resident had moderate cognitive impairment and required staff supervision with activities of daily living (ADLs.) Observation on 09/23/215 at 8:35 A.M. of medication administration for Resident #39 per Licensed Practical Nurse (LPN) #430 revealed the nurse was wearing gloves and was touched the medication cart and medication cart computer. LPN #430 then opened a sealed medication pouch containing individually sealed doses of medications for Resident #39. LPN #430 opened each individual medication plastic container and placed each individual pill in the palm of her gloved hand and then put the pill in a plastic medication cup. LPN #430 completed this process for medications that included Aldactone 25 milligrams (mg) oral tablet, Bumex one mg oral tablet, Farxiga 10 mg oral tablet, Metoprolol 50 mg Extended Release 24-hour sprinkle oral capsule, multi-vitamin oral tablet, and Apixaban five mg oral tablet. LPN #430 then poured a cup of water from a water pitcher with her gloved hands and passed the water cup to Resident #39 by pinching the cup with her gloved thumb inside of the water cup, nearly touching the water inside the cup, and her index finger on the outside of the cup. Resident #39 took the oral medications in the plastic medicine cup and drank from the water cup. Interview on 09/23/25 at 8:42 A.M. with LPN #430 verified her gloves were contaminated when she placed the oral medications in the palm of her hand before placing them in the plastic medication cup. LPN #430 confirmed this action contaminated each of the tablets/capsules. LPN #430 further confirmed she did not handle the water cup in a manner to prevent contamination when she passed the cup to Resident #39 with her thumb and index finger. Review of the facility policy titled General Guidelines for Medication Administration dated 06/21/17 revealed the nurse should cleanse hands as appropriate, pour the correct number of tablets or capsules in the medication cup, and never touch any of the medication with fingers. 2. Review of the medical record for Resident #19 revealed an admission date of 03/14/24 with diagnoses including vascular dementia, type two diabetes mellitus, major depressive disorder, and epilepsy. Review of the MDS assessment for Resident #19 dated 07/23/25 revealed the resident had severe cognitive impairment and required assistance from staff with ADLs. Review of section K revealed the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had a five percent weight loss or more in the last month and received feeding tube and a mechanically altered diet. Review of the physician's orders for Resident #19 revealed an order dated 08/12/25 for the resident to be on Enhanced Barrier Precautions (EBP) related to gastrostomy tube (g-tube) and a history of multi-drug-resistant organism (MDRO) infection. Observation on 09/23/25 at 12:15 PM revealed Resident #19 had no signage on the door regarding EBP nor was there personal protective equipment (PPE) outside the room. Interview on 09/23/25 at 12:42 PM with LPN #402 verified Resident #19 had an order for EBP but did not have a sign on the door indicating her was in EBP nor was there PPE outside the resident's room for staff to use. Observation on 09/24/25 at 10:11 A.M. revealed Certified Nursing Assistant (CNA) #522 provided hands-on care to Resident #19 without donning a gown prior to entering the room. Interview on 09/24/25 at 10:31 A.M. with CNA #522 verified she did not wear a gown when providing care to Resident #19. 3. Review of the medical record for Resident #85 revealed an admission date of 07/18/25 with diagnoses including chronic pulmonary edema, hypertension, malignant neoplasm of the breast, cerebral infarction, acute respiratory failure, and bone cancer. Review of the MDS assessment for Resident #85 dated 08/30/25 revealed the resident had impaired cognition and required maximum assistance with ADLs. Review of physician's orders for Resident #85 dated September 2025 revealed the resident was to be on neutropenic precautions as the resident received cancer infusion treatments. Observation on 09/23/25 at 11:14 A.M. of Resident #85's room revealed there was a sign on the door indicating the resident was on neutropenic precautions. Instructions included the following: perform hand hygiene when entering and before leaving the room, put on gloves before entering and remove before leaving the room, put on gown before entering and remove before leaving room, put on mask before entering room, if you have a respiratory infection. Observation on 09/23/25 at 11:15 A.M. revealed CNA #82 exited Resident #85's room into the hallway and was wearing gloves and carrying a bag of soiled linen. Observation on 09/23/25 at 11:16 A.M. revealed LPN #430 told CNA #825 she should wear full PPE and follow the neutropenic precautions for Resident #85 per the instructions on the door. CNA #825 told the nurse she had not seen the sign on the door. Interview on 09/23/25 at 11:17 A.M. with CNA #825 verified she had exited Resident #85's room wearing the same gloves used while providing peri care. The CNA verified she had not washed her hands after providing care and had not worn a gown during care. CNA #825 verified there was no trash disposal inside or outside the resident's room. CNA #825 confirmed she had not followed the infection control practices listed on Resident #85 door sign. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/23/25 at 11:18 A.M. with LPN #430 verified Resident #85 had orders for neutropenic precautions and CNA #825 had not followed them. 4. Review of the medical record of Resident #81 revealed an admission date of 09/12/25 with diagnoses including metabolic encephalopathy, open wounds of right upper arm and left lower leg, congestive heart failure, and type two diabetes mellitus. Review of the comprehensive MDS assessment for Resident #81 dated 09/18/25 revealed the resident had moderately impaired cognition and required staff assistance with ADLs. Review of the physician's orders for Resident #81 revealed an order dated 09/13/25 for the resident to be in contact precautions related to vancomycin resistant enterococcus (VRE) in the urine. Review of the care plan for Resident #81 dated 09/14/25 revealed the resident had a MDRO infection related to VRE. Interventions included contact precautions. Observation on 09/22/25 at 10:06 A.M. revealed there was a sign Resident #81's indicating the resident was to be on contact precautions. There was a bin outside Resident #81's room, containing gloves, gowns, and masks. Further observation revealed CNAs #525 and #610 were in Resident #81's room assisting the resident in the bathroom, but neither CNA was wearing a gown. Interview on 09/22/25 at 10:16 A.M. with CNAs #525 and #610 confirmed they did not don gowns prior to providing toileting assistance to Resident #81. 5. Observation on 09/23/25 between 12:10 P.M. and 12:15 P.M. revealed CNAs #525 and #610 delivered lunch trays to residents #31, #65, and #86. CNAs #525 and #610 went in and out of the residents' rooms, physically assisted residents with tray setup, and answered call lights. CNAs #525 and #610 did not perform hand hygiene. Interview on 09/23/25 at 12:16 P.M. with CNAs #525 and #610 verified they did not perform hand hygiene between each tray passed and confirmed they answered call lights and physically assisted residents with tray setup but did not perform hand hygiene at any time during that period. Review of the facility policy titled Standard Precautions dated 2001 revealed hand hygiene with soap or an alcohol-based hand rub (ABHR) should be used before and after contact with a resident and after contact with items in a resident's room.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, family interview, and policy review, the facility failed to ensure responsible parties and/or physicians were notified of significant weight loss. This affected three (#45, #61 and #19) of the three residents reviewed for nutrition. The facility census was 75. Findings included: 1) Review of the medical record of Resident #45 revealed an admission date of 02/16/23. Diagnoses included type two diabetes mellitus, depression, Alzheimer's disease with behavioral disturbance, depression, anxiety, hypertension, Review of the quarterly Minimum Data Set (MDS) assessment for Resident #45 dated 07/10/25, revealed the resident had severely impaired cognition. The resident was independent or required set-up or supervision for all activities of daily living (ADLs). The resident weighed 177 pounds and had a significant non-prescribed weight loss. Review of Resident #45's weights revealed the following: a) On 01/08/25, the resident weighed 190.8 pounds (lb). b) On 02/01/25, the resident weighed 191.2 lb. c) On 03/01/25, the resident weighed 189.2 lb. d) On 04/12/25, the resident weighed 190.4 lb. e) On 05/01/25, the resident weighed 188.4 lb. f) On 06/02/25, the resident weighed 187.6 lb. g) On 07/02/25, the resident weighed 176.8 lb. h) On 08/01/25, the resident weighed 172.6 lb. i) On 09/08/25, the resident weighed 168.2 lb. Review of a progress note for Resident #45 dated 07/03/25, revealed the resident triggered for a weight loss of greater than five percent (%) for one month. The progress note had no documented evidence that the resident's responsible party and physician were notified. Review of a progress note for Resident #45 dated 08/05/25, revealed the resident triggered for a nine % loss for three months. The progress note had no documented evidence that the resident's responsible party and physician were notified. Review of a progress note for Resident #45 dated 09/09/25, revealed the resident triggered for a weight loss of greater than 10 % for six months. The progress note had no documented evidence that the resident's responsible party and physician were notified. Interview via telephone on 09/22/25 at 2:51 P.M., Resident #45's responsible party stated she had not been notified that Resident #45 had recently experienced a significant weight loss. Interview on 09/25/25 at 12:21 P.M., Registered Dietitian (RD) #605 stated she did not notify Resident #45's responsible party of his weight loss and stated she was not aware of anybody else notifying the resident's responsible party of the weight loss. RD #605 stated she recently found out she was responsible for notifying responsible parties of significant weight loss. Interview on 09/25/25 at 4:12 P.M., Nurse Practitioner (NP) #950 stated she was not made aware of Resident #45's weight loss. NP #950 stated she is at the facility five days a week and verified her expectation is to be notified of residents who have significant weight loss. 2) Record review of Resident #61 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #61 include diabetes, depression, and diarrhea unspecified. The resident had a sister who was the Power of Attorney, (POA), and was listed as an emergency contact. Review of NP #950 progress notes dated 01/14/25, revealed Resident #61 was diagnosed with herpes zoster, (shingles) and prescribed Benadryl for itching. There was no documented evidence that the resident's POA was notified of the new diagnosis and the change in condition. Review of the nursing progress notes for Resident #61 dated 01/14/25 through 01/21/25, including an Interdisciplinary Team (IDT) Meeting note dated 01/20/25, revealed the POA was not notified of the resident's new diagnosis and the condition change. Review of the MDS comprehensive assessment for Resident #61 dated 09/8/25, revealed the resident had intact cognition and had mobility independence. Interview on 09/22/24 at 9:30 A.M. with Resident #61, revealed she wanted her sister, the emergency contact and her POA, to be contacted if her condition changed. The resident stated she recalled having a red itchy rash a few months ago and was prescribed some medicine. Interview on 09/24/25 at 1:30 P.M. the Regional Nurse #900 verified there was no documentation of Resident #61's POA being notified of new diagnosis and change in condition on 01/14/25. Interview on 09/24/25 at 4:02 P.M. the NP #950 verified the (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #61 had a new diagnosis and received medication for shingles. The NP #950 stated she did not inform the family representative of the new diagnosis, as the nurses were to notify family representatives of condition changes and new diagnosis. 3) Review of the medical record for Resident #19 revealed an admission date of 03/14/24. Diagnoses included vascular dementia, type II diabetes mellitus (DM II), major depressive disorder, and epilepsy. Review of the Significant Change MDS assessment dated [DATE] revealed Resident #19 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of two. This resident was assessed to require partial assistance with eating, transfers, and dressing, and substantial assistance with toileting and bathing. Review of section K (swallowing disorders) revealed Resident #19 had a five percent weight loss or more in the last month and received feeding tube and a mechanically altered diet. Review of the weights for Resident #19 revealed a significant weight loss occurred from 06/22/25 at 142.4 lb. to 07/06/25 at 134.2 lb. which equaled 8.2 lb. loss or 5.76 percent (%) weight loss. Interview on 09/25/25 at 12:18 P.M. with RD #605, verified she did not notify Resident #19's guardian of her significant weight loss because she was not aware she was responsible for notifying families as of last week. Review of the facility policy titled, Change in a Resident's Condition or Status, dated 05/2017, revealed the attending physician and resident representative would promptly be notified of a change in a resident's medical condition or status. This deficiency represents non-compliance investigated under Complaint Numbers 2643343, 2626386, 2592408, 1335088 and 1335087.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 interview and record review, the facility failed to notify the Ombudsman's Office after residents were discharged to the hospital. This affected three residents (#02, #64 and #19) of the four residents reviewed for hospital discharge. The facility census was 75. Findings include: 1) Record review of Resident #02 revealed the resident was admitted to the facility on [DATE]. The resident was discharged to the hospital from [DATE] to 07/04/25 and 07/09/25 to 07/11/25. Diagnoses for Resident # 2 included surgical after care of 07/04/25, dementia, diabetes, osteoarthritis of left hip, peripheral vascular disease, and heart failure. Review of the Minimum Data Set, (MDS) comprehensive assessment for Resident #02 dated 08/08/25, revealed the resident had intact cognition. 2) Record review of Resident #64 revealed the resident was admitted to the facility on [DATE]. The resident was discharged to the hospital from [DATE] to 07/03/25 and 07/31/25 to 08/05/25. Diagnoses for Resident #64 include metabolic encephalopathy, arthritis, morbid obesity, urinary tract infection nonspecific, chronic kidney disease, depressive disorder, heart disease, overactive bladder, diabetes, dysuria, and calculus of kidney. Review of the MDS comprehensive assessment for Resident #64 dated 07/31/25, revealed the resident had impaired cognition and required partial assistance with hygiene, dependent on staff for toileting and maximum assistance with mobility. Interview on 09/23/25 at 9:44 A.M., the Social Service Designee, (SSD) #150 stated she had no evidence the Ombudsman's Office was notified Resident #02 was discharged to the hospital 06/27/25 to 07/04/25 and on 07/09/25 to 07/11/25, or when Resident #64 was discharged to the hospital from 06/25 to 07/03/25 and on 07/31/25 to 08/05/25. The SSD #150 stated the Ombudsman's Office should be notified monthly of residents who are discharged from the facility. 3) Review of the medical record for Resident #19 revealed an admission date of 03/14/24. Diagnoses included vascular dementia, type II diabetes mellitus (DM II), major depressive disorder, and epilepsy. Resident #19 was hospitalized from [DATE] through 08/11/25. Review of the Significant Change MDS assessment for Resident #19 dated 07/23/25, revealed Resident #19 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of two. This resident was assessed to require partial assistance with eating, transfers, and dressing, and substantial assistance with toileting and bathing. Interview on 09/24/25 at 4:10 P.M. with the Administrator, verified she did not have any records of notification to the Ombudsman's Office when Resident #19 was hospitalized .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview, and policy review, the facility failed to provide needed personal care for three (#07, #41 and #55) of the three residents reviewed for personal care. The facility census was 75. Findings included: 1) Review of the medical record revealed Resident #07 was admitted to the facility on [DATE]. Diagnoses included end stage renal disease (ESRD) with dependence on hemodialysis, diabetes mellitus type II, cerebral infarction with aphasia and hemiplegia (left non-dominant side). Review of Plan of Care for Resident #07 dated 04/20/22, revealed Resident #07 required assistance with activities of daily living (ADLs) related to debility, decreased mobility, self-care deficit related to diagnoses including, but not limited to, cerebral vascular accident (CVA) sequelae with left side hemiplegia/paresis, end stage renal disease with hemodialysis, seizure disorder, encephalopathy, and diabetes mellitus type II, with an intervention of nail care as needed. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE], revealed Resident #07 had intact cognition and was dependent on staff for personal care and hygiene. Observation on 09/25/25 at 4:42 P.M. revealed Resident #07's fingernails were excessively long and with an unknown brown material underneath the nails. The fingernails extended approximately one inch past the end of the finger. Interview with Resident #07 at the same time, revealed he wanted his fingernails to be cut and cleaned. When asked if he wanted his fingernails cut and cleaned, Resident #07 responded by nodding his head up and down indicating yes. 2) Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included myocardial infarction, pulmonary edema, spinal stenosis, history of lumbar wedge fracture, and atherosclerosis of bilateral legs. Review of Plan of Care for Resident #41 dated 02/08/21 revealed Resident #41 required assistance with ADLs related to decreased mobility, self-care deficit related to diagnoses including, but not limited to, spinal stenosis, history of lumbar wedge fracture, and chronic pulmonary edema with an intervention of nail care as needed. Review of the MDS Quarterly assessment dated [DATE] revealed Resident #41 had intact cognition and was dependent on staff for personal care and hygiene. Observation on 09/25/25 at 4:50 P.M. revealed Resident #41's fingernails were excessively long and with an unknown brown material underneath the nails. The fingernails extended approximately one inch past the end of the finger. Interview with Resident #41 at the same time, revealed the resident wanted her fingernails to be cut and cleaned. Interview and observation on 09/25/25 at 4:55 P.M. with Certified Nursing Assistant (CNA) #527 verified the condition of Residents #07 and #41 fingernails and the need for nail care to be completed. 3) Review of the medical record for Resident #55 revealed an admission date of 06/07/23. Diagnoses included chronic obstructive pulmonary disease (COPD), acute and respiratory failure with hypoxia, and type II diabetes mellitus. Review of the Care Plan dated 03/02/25 revealed Resident #55 required assistance with ADLs related to decreased mobility and self-care deficit. Interventions included assist as needed with shower twice weekly or per preference, observing for fatigue and providing rest periods as needed, assist with personal hygiene as needed, and assist with ADLs on daily basis. Review of the Quarterly MDS assessment dated [DATE], revealed Resident #55 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 and was dependent on staff for hygiene and personal care. Review of the shower sheets for Resident #55, revealed no documented evidence of showers on 08/16/25, 08/20/25, 08/23/25, 09/09/25, 09/17/25, and 09/20/25. Interview on 09/24/25 at 4:10 P.M. with the Administrator, verified there were no documented showers for Resident #55 during those missing days. Review of the facility policy titled, Activities of Daily Living, Supporting, revised March 2018 revealed residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene. This deficiency represents non-compliance investigated under Complaint Numbers 2626386 and 2564609.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Bradford Place Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Millville Avenue Hamilton, OH 45013	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on medical record review, staff interview, and review of the facility policy, the facility failed provide tube feedings as ordered. This affected one (Resident #19) of four residents reviewed for unplanned weight loss. The facility census was 75 residents. Findings include: Review of the medical record for Resident #19 revealed an admission date of 03/14/24 with diagnoses including vascular dementia, type two diabetes mellitus, major depressive disorder, and epilepsy. Review of the Minimum Data Set (MDS) assessment for Resident #19 dated 07/23/25 revealed the resident had severe cognitive impairment, required partial assistance with eating, had a five percent or greater weight loss during the review period, and received a mechanically altered diet supplemented with tube feedings. Review of the physician's orders for Resident #19 revealed order dated 08/28/25 for the resident to receive a supplemental feeding via gastrostomy tube (g-tube) of Jevity 1.5 Cal, 237 milliliters if the resident's meal consumption was less than 75 percent (%). Review of the Medication Administration Record (MAR) for Resident #19 dated September 2025 revealed the resident did not receive tube feeding as ordered on the following dates: 09/07/25, 09/10/25, 09/12/25. Interview on 09/25/25 at 12:34 P.M. with Registered Dietician (RD) #605 verified Resident #19 did not receive supplemental tube feeding as ordered on the following dates: 09/07/25, 09/10/25, 09/12/25. Review of the facility policy titled Nutrition/Hydration Status Maintenance dated November 2017 revealed the facility must ensure a resident was offered a therapeutic diet when there was a nutritional problem, and the health care provider ordered a therapeutic diet when indicated.		

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NAME OF PROVIDER OR SUPPLIER Bradford Place Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Millville Avenue Hamilton, OH 45013	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to administer medications as ordered by the physician. This affected one (Resident #08) of four residents reviewed for medication administration. The facility census was 75 residents. Findings include: Review of the medical record for Resident #08 revealed an admission date of 10/14/22 with diagnoses including thoracic, thoracolumbar and lumbosacral intervertebral disc disorder, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #08 dated 08/20/25 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.) Review of the physician ' s orders for Resident #08 revealed an order dated 09/02/25 for Ambien five milligrams (mg) give one-half tablet by mouth at bedtime Review of the controlled drug receipt/record disposition form for Resident #08 ' s Ambien revealed the medication was not signed out and documented as administered on 09/19/25, 09/22/25 and 09/23/25 and five Ambien tablets should remain in the blister pack. Interview on 09/24/25 at 8:19 A.M. with Resident #08 confirmed she had not received Ambien for three nights in the past week. Observation on 09/24/25 at 8:28 A.M. with Licensed Practical Nurse (LPN) #483 revealed five Ambien tablets remained available in the blister pack for Resident #08. Interview on 09/24/25 at 8:29 A.M. with LPN #483 verified confirmed Ambien was not signed out as administered on 09/19/25, 09/22/25 and 09/23/25, and that the number of Ambien available in the blister pack matched the number of Ambien documented as being available on the controlled drug receipt/record disposition form. Interview on 09/25/25 at 8:52 A.M. with Registered Nurse [NAME] President of Clinical Operations (RN/VPCO) #900 verified Resident #08 ' s Ambien was not signed out on 09/19/23, 09/22/25 and 09/23/25. RN/VPCO #900 further confirmed that because the number of Ambien available on the controlled drug receipt/record disposition form matched the actual amount of Ambien available in the medication cart, the resident had not been administered the medication as ordered on 09/19/25, 09/22/25, and 09/23/25. Review of the policy titled Medication Administration dated 06/21/17 revealed medications should be administered as ordered. This deficiency represents noncompliance investigated under Complaint Number 2592408 and Complaint Number 1335091 and Complaint Number 1335087.		

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NAME OF PROVIDER OR SUPPLIER Bradford Place Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 Millville Avenue Hamilton, OH 45013	
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents were offered pneumococcal vaccines as required. This affected one (Resident #19) of five residents reviewed for immunizations. The facility census was 75 residents. Findings include: Review of the medical record for Resident #19 revealed an admission date of 03/14/24 with diagnoses including vascular dementia, type two diabetes mellitus, major depressive disorder, and epilepsy. Review of the Minimum Data Set (MDS) assessment for Resident #19 dated 07/23/25 revealed the resident had severe cognitive impairment and required assistance from staff with activities of daily living (ADLs.) Review of the medical record for Resident #19 revealed it did not include documentation of the facility offering the resident and/or reaching out to the resident's representative regarding consent for a pneumococcal vaccination. Interview on 09/29/25 at 11:23 A.M. with the Director of Nursing (DON) confirmed the medical record for Resident #19 did not include documentation of the facility offering the resident and/or reaching out the resident's representative regarding consent for a pneumococcal vaccine. Review of the facility policy titled Pneumococcal Vaccine dated October 2023 revealed all residents were offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infection. Prior to or upon admission, residents were assessed for eligibility to receive a pneumococcal vaccine series, and when indicated, were offered the vaccine series within 30 days of admission to the facility		