STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365293	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Airy Gardens Rehabilitation and Nursing Center	2250 Banning Road Cincinnati, OH 45239

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to ensure catheter bags were covered. This affected two (Residents #235 and #236) of three residents reviewed for catheters. The facility census was 77. Findings include: 1. Review of the medical record for Resident #235 revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, diabetes mellitus type two, and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment for Resident #235 dated 02/10/25 revealed the resident had severe cognitive impairment, was always incontinent of bowel, had an indwelling foley catheter, and was dependent on staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #235 revealed an order dated 08/03/23 for staff to change the indwelling catheter and drainage bag as needed for leakage or blockage. Observation on 02/19/25 at 9:55 A.M. revealed Resident #235 was in his room, and his catheter bag was full of urine which was visible from the hallway. Resident #235's catheter bag was not covered with a dignity bag. Interview on 02/19/25 at 9:57 A.M. with Registered Nurse (RN)#315 confirmed Resident #235's catheter bag was not covered with a dignity bag and confirmed catheter bags should be covered. 2. Review of the medical record for Resident #236 revealed an admitted [DATE] with diagnoses of other complications of incontinent external stoma of urinary tract, chronic kidney disease stage, and cerebral infarction. Review of the MDS assessment for Resident #236 dated 01/30/25 revealed the resident was cognitively intact, was continent of bowel, had a nephrostomy tube, and required staff assistance with ADLs. Review of the plan of care for Resident #236 dated 01/24/25 revealed the resident had altered urinary elimination with an intervention to ensure a privacy bag covered the nephrostomy bag at all times. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/19/25 revealed Resident #236 had the nephrostomy tube in place with a leg bag pinned to the outside of his pajama pants. The leg bag had visible urine in it and was not covered with a dignity bag. Interview on 02/19/25 at 10:05 A.M. with Licensed Practical Nurse (LPN) #500 confirmed Resident #236's nephrostomy bag was not covered with a dignity bag and confirmed catheter bags should be covered. Review of the policy titled Catheter Care, dated 2024 revealed the facility staff would ensure residents with indwelling catheters received appropriate care to maintain resident dignity and privacy when indwelling catheters were in use. Privacy bags would be available and catheter drainage bags would be covered at all times while in use.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, observation, staff interview, resident interview, and review of the facility policy, the facility failed to ensure a safe, clean and homelike environment. This affected one (Residents #59) of four residents reviewed for physician environment and had the potential to affect two (Residents #27 and #238) of seven residents residing on the Heritage nursing unit. The facility census was 77 residents. Findings include: 1. Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses including lupus, epilepsy, and hypertension Review of the Minimum Data Set (MDS) assessment for Resident #59 dated 01/07/25 revealed the resident was cognitively intact and required supervision with activities of daily living (ADLs.) Observation on 02/18/25 at 10:25 A.M. revealed the wall by Resident #59's bathroom door had a missing section of cove base. The sink in the room was not properly secured and was able to be moved in all directions. There was a wide gap with no grout between the countertop and backsplash. The wall between the closet and sink had exposed drywall and needed to be patched and painted. There was an extra cable wire laying on the floor by the door. Interview on 02/18/25 at 10:25 A.M. with Resident #59 confirmed he was not pleased with the missing cove base, the condition of the sink and countertop area, and the extra cable wire on the floor in his room. Resident #59 was unable to recall if he had reported these concerns. Interview on 02/20/25 from 12:55 P.M. with Housekeeping Director (HD) #341 confirmed the physical environment concerns in Resident #59's room. 2. Observation of the shower room on the Heritage nursing unit revealed the shower room ceiling had damaged drywall that was peeling and in need of repair/replacement and painting. Interview on 02/20/25 at 1:09 P.M. with HD #341 confirmed the Heritage nursing unit shower room ceiling had damaged drywall that was peeling and in need of repair/replacement and painting. Interview on 02/20/25 at 1:20 P.M. with Registered Nurse (RN) #316 confirmed Residents #27 and #238 were the only resident of the seven residents residing on the Heritage nursing unit who had the ability to use the shower room. Review of the policy titled Resident Rights dated 2024 revealed the resident had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observation, and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately. This affected three (Residents #77, #8, #51) of four residents reviewed for MDS assessment accuracy. The facility census was 77 resident. Finding include: 1. Review of the medical record for Resident #77 revealed an admission on 07/25/24 with diagnoses including atherosclerosis, urinary tract infections, asthma, and diabetes mellitus. Review of the admission MDS assessment for Resident #77 dated 08/01/24 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the medical record for Resident #77 revealed an entry MDS assessment was completed on 07/25/24, a discharge return anticipated assessment was completed on 07/29/24, and a comprehensive assessment with an assessment reference date (ARD) of 08/01/24 was completed and transmitted. Interview on 02/19/25 at 2:17 P.M. with Minimum Data Coordinator Registered Nurse (RN) #311 confirmed the comprehensive MDS assessment was dated 08/01/24 after Resident #77 had discharged from the facility. RN #311 confirmed the discharge MDS should have been changed to reflect a five-day assessment, and the nurse would deactivate the inaccurate MDS that was submitted for Resident #77 on 08/01/24. 2. Review of the medical record for Resident #8 revealed an admission on 08/03/18 with diagnoses including dementia with behavioral disturbances and psychotic disorders with delusions. Review of the annual MDS assessment for Resident #8 revealed the resident was cognitively impaired and required set up with ADLs. Review of the plan of care for Resident #8 revealed resident was admitted to hospice services on 01/29/24. Interventions include assess advance directive upon admission, quarterly annually and with significant change. Review of the physician's orders for Resident #8 revealed an order dated 01/29/24 for the resident to be admitted to hospice. Review of the fall investigation for Resident #8 dated 03/19/24 revealed the resident was found in the room on the floor after an attempted self-transfer without injury. Review of the MDS assessment for Resident #8 dated 04/30/24 revealed the assessment did not reflect the resident's fall on 03/19/24 and did not reflect the resident's admission to hospice. Review of the MDS assessment for Resident #8 dated 07/31/24 revealed the assessment did not reflect the resident's admission to hospice. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/25 at 2:45 P.M. with Registered Nurse (RN) #311 confirmed the MDS assessment for Resident #8 dated 04/30/24 was not accurate as it did not include the fall that occurred on 03/19/24 or that the resident was receiving hospice services. RN #311 confirmed the MDS assessment for Resident #8 dated 07/31/24 was not accurate as it was not coded to reflect the hospice services provided for the resident. 49771 3. Review of the medical record for Resident #51 revealed an admitted [DATE] with diagnoses including cerebral infarction with non-dominant (left) side hemiplegia and hemiparesis, diabetes mellitus type two, chronic kidney disease, and depression. Review of the MDS assessment for Resident #51 dated 02/09/25 revealed the resident moderately cognitively impaired and required staff assistances with ADLs. The assessment did not reflect contractures or limitations in the resident's range of motion. Observation on 02/18/25 at 10:33 A.M. revealed Resident #51's left hand was contracted. Observation on 02/20/25 at 3:57 P.M. with Rehab Director (RD) #363 revealed RD #363 found a left-hand splint in the resident's belongings on the sink counter. Interview on 02/20/25 at 3:57 P.M. with RD #363 confirmed she had been unaware Resident #51 had a contracture of his left hand. Interview on 02/20/25 at 4:00 P.M. with RN #311 confirmed the MDS assessment for Resident #51 dated 02/09/25 was inaccurate as it did not reflect contractures or limitations in the resident's range of motion. Interview on 02/20/25 at 4:10 P.M. with RD #363 confirmed Resident #51 had received therapy treatment for a left-hand contracture in September 2024.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51069 Based on medical record review and staff interview, the facility failed to ensure completion of significant change Preadmission Screening and Resident Reviews (PASARRs.) This affected one (Resident #28) of two residents reviewed for PASARR status. The facility census was 77 residents. Findings include: Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, hypertension, congestive heart failure, unspecified dementia, and schizophrenia. Review of the physician's orders for Resident #28 revealed an order dated 07/18/24 for admission to hospice. Review of the medical record for Resident #28 revealed the facility completed a significant change Minimum Data Set (MDS) assessment for the resident due to admission to hospice on 07/18/24. Review of the medical record for Resident #28 revealed the facility did not complete an update PASARR for the resident following the resident's hospice admission. Interview on 02/20/25 at 11:11 A.M. with Social Services Director (SSD) #353 confirmed the facility had not completed an updated PASARR for Resident #28 following the resident's admission to hospice and the facility should have completed a new PASARR on 07/18/24 when the resident received the new order to admit to hospice services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39702 Based on medical record review and staff interview, the facility failed to ensure care plans were updated to accurately reflect resident health care status. This affected one (Resident #72) of three residents reviewed for care plans. The facility census was 77 residents. Findings include: Review of the medical record for Resident #72 revealed an admitted [DATE] with diagnoses including schizophrenia, subdural hemorrhage, traumatic brain injury, gastrostomy (g-tube) status and dislocation of right acromioclavicular joint. Review of the physician's orders for Resident #72 revealed orders dated 09/25/24 to flush the g-tube with thirty cubic centimeters (cc) of water every shift to maintain patency and orders for a regular diet, regular texture with thin liquids. Review of the plan of care for Resident #72 dated 09/26/24 revealed the resident required tube feeding related to dysphagia with interventions including the following: assess feeding tube placement, patency, and residual every shift and before and after administration of any fluids or medications, check for tube placement and gastric contents/residual volume per facility protocol and record, hold feed if greater than 100-200 cubic centimeters (cc) aspirate, discuss with resident/family/caregivers any concerns about tube feeding, advantages, disadvantages, potential complications, does not like food related activities as it is upsetting to see others eating, head of bed elevated 45 degrees during and thirty minutes after tube feed, medication administration: may cocktail medications and administer via g-tube, monitor intake and output every shift, monitor lung sounds every shift and as needed, monitor for coughing, shortness of breath , choking, labored respirations, monitor/document/report to physician as needed tube dysfunction or malfunction, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, and needs assistance/supervision/cueing with tube feeding and water flushes, registered dietician to monitor caloric intake, estimate needs, make recommendations for changes to tube feeding as needed. Review of the progress note for Resident #72 dated 12/02/24 per Nurse Practitioner (NP) #505 revealed the resident was no longer using the g-tube and the NP recommended discontinuation of the tube. Review of the progress note for Resident #72 dated 01/02/25 per NP #500 revealed the resident requested to have the g-tube removed and was scheduled for an outpatient procedure to remove the tube. Review of the Minimum Data Set (MDS) assessment for Resident dated 01/02/25 for Resident #72 revealed resident had impaired cognition and was independent in eating, toileting, bed mobility and transfers. Dietary administration via g-tube was not coded during the assessment period. Interview on 02/19/25 at 4:38 P.M. with Registered Nurse (RN) #311 confirmed Resident #72's care plan was not updated with the removal of the g-tube and Resident #72's care plan was not accurate as the resident never used the g-tube for nutritional support. RN #311 confirmed Resident #72 was on a regular diet and able to consume meals orally. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/25 at 2:46 P.M. with NP #505 confirmed the g-tube for Resident #72 was never used for nutritional support.

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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** 39702 Based on medical record review observations, staff interviews and policy review, the facility failed to ensure timely suture removal. This affected one Resident (#73) of the one resident reviewed for facial lacerations. The facility census was 77. Findings included: Review of the medical record for Resident #73 revealed an admitted [DATE] with diagnoses including but not limited to history of physical injury and trauma, traumatic brain injury and altered mental status. Review of the plan of care for Resident #73 revealed resident at risk for falls related to balance problems, poor communication and comprehensive, and traumatic brain injury. Interventions include to anticipate and meet needs, follow facility fall protocol and notify physician and power of attorney (POA) of falls. Review of the most recent Minimum Data Set (MDS) assessment for Resident #73 revealed the resident was cognitively impaired. Review of the hospital discharge summary dated 01/24/25 revealed Resident #73 fell while at the hospital due to gastrostomy (g-tube) displacement sustaining a two-centimeter laceration to the right eyebrow. The discharge summary revealed no orders for suture removal. Review of the physician's orders for Resident #73 revealed an order dated 01/24/24 to monitor sutures to right eyebrow two times a day and there was no additional order for the sutures to be removed. Observation of Resident #73 on 02/18/25 at 10:45 A.M., revealed resident lying in bed. Observation of sutures to area of right eyebrow without sign or symptoms of infections. Interview with Resident #73 at the same time revealed she received the suture from a fall. Resident #73 was unable to provide date of fall or additional details of fall. Interview with Licensed Practical Nurse (LPN) #359 on 02/19/25 at 10:00 A.M., verified Resident #73 went to the hospital after she pulled her g-tube out. LPN #359 stated the resident fell from a stretcher while she was in the emergency room and returned with sutures in place. LPN #359 verified the resident had sutures still in place over her right eyebrow and verified there was not an order for the resident's sutures to be removed. Interview with Assistant Director of Nursing (ADON) #316 on 02/19/25 at 10:57 A.M., revealed the Wound Nurse Practitioner (WNP) was following Resident #73 for a sacral wound but was not following the resident for the wound with sutures. ADON #316 stated sutures should be removed after seven to ten days. ADON #316 verified Resident #73 had sutures in place and the facility did not have any orders to remove them.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observation, staff interview, and resident interview, the facility failed to ensure residents received care and services for management of contractures and impaired mobility. This affected three (Residents #9, #72, #51) of three residents reviewed for range of motion services. The facility census was 77 residents. Findings include: 1. Review of the medical record for Resident #9 revealed an admission on 03/18/16 with diagnosis including peripheral vascular disease, diabetes mellitus, traumatic brain injury, and schizophrenia. Review of the Minimum Data Set (MDS) assessment for Resident #9 dated 12/25/24 for Resident #9 revealed the resident had impaired cognition and required supervision with activities of daily living (ADLs). Review of the care plan for Resident #9 dated 11/22/22 revealed the resident had an ADL self-care performance deficit related to cardiovascular disease. Interventions included staff to apply a left-hand resting hand orthotic as ordered. Review of the physician's orders for Resident #9 revealed an order dated 04/05/22 for the resident to wear left resting hand orthotic for six to eight hours as tolerated in order to promote skin joint integrity. The order also included instructions for staff to monitor skin integrity and document refusals every shift. Observation on 02/18/25 at 10:51 A.M. revealed Resident #9 was lying in bed without a brace on left hand. Observation on 02/19/25 at 10:10 A.M. revealed Resident #9 was lying in bed without a brace on left hand. Interview on 02/20/25 at 12:20 P.M. with Certified Nursing Assistant (CNA) # 323 and CNA #325 confirmed Resident #9 had not had a brace on all day. CNA #325 confirmed she had never placed a brace to Resident #9 's left hand. CNA #323 and CNA #325 confirmed they were unable to locate a brace for Resident #9. Interview on 02/20/25 at 12:40 P.M. with the Administrator confirmed Resident #9 was resting in bed and did not have the brace applied as ordered to left hand. Administrator further the nurse had documented Resident #9's skin was checked as ordered on 02/20/25. Interview on 02/20/25 at 12:40 P.M. with Resident #9 revealed the resident shook her head in a yes motion when asked if she wanted to have the splint applied. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #72 revealed an admitted [DATE] with diagnoses including traumatic subdural hemorrhage, traumatic brain injury, cervical fracture, dislocation of right acromioclavicular joint and injury in motor vehicle accident. Review of the MDS assessment for Resident #72 dated 01/02/25 revealed the resident had moderately impaired cognition, required supervision with ADLs, and was coded as having no functional limitation to the bilateral upper extremities. Review of the plan of care for Resident #72 revealed the resident had an alteration in musculoskeletal status related to fractures from a motor vehicle accident. Interventions included the following: anticipate needs, encourage gentle range of motion daily two times a day morning and evening, see physical treatment plan. Review of the physician's progress note for Resident #72 dated 11/07/24 revealed the resident complained about soreness to his right shoulder and was currently working with physical therapy. The physician referred Resident #72 to orthopedics for a right shoulder evaluation. Review of the physician's orders for Resident #72 revealed an order dated 11/22/24 for staff to encourage the resident to apply a sling to his right arm and shoulder every shift. Review of the physician's progress note for Resident #72 dated 12/02/24 revealed the resident continued to complain about discomfort to his right shoulder and was working with physical therapy. Review of the physical therapy evaluation for Resident #72 dated 12/05/24 revealed the resident's right upper extremity range of motion was impaired and the resident presented with limited strength and range of motion needed for safe mobility. Review of the Medication Administration (MAR) for Resident #72 dated February 2025 revealed facility nurses initialed the order to encourage resident to apply sling to right arm and shoulder every shift with no documented refusals. Observation on 02/18/25 at 11:40 A.M. revealed Resident #72 was ambulating in his room and was not wearing a sling. Observation on 02/19/25 at 9:40 A.M. of revealed Resident #72 was ambulating in his room and was not wearing a sling. Observation on 02/20/25 at 10:19 A.M. revealed Resident #72 was sitting in his room and was not wearing a sling. Observation on 02/20/25 at 10:22 A.M. with CNA #323 revealed the aide searched for Resident #72's sling but was unable to locate it. Interview on 02/20/25 at 10:22 A.M. with CNA #323 confirmed she had never seen Resident #72 wear a sling and she routinely cared for the resident. CNA #323 further confirmed Resident #72 went out of the facility with a family member and did not wear a sling. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/25 at 11:45 A.M. with CNA #329 confirmed Resident #72 did not have a sling present in his room and the aide could not remember when the resident was seen wearing a sling. Interview on 02/20/25 at 12:10 P.M. with Licensed Practical Nurse (LPN) #303 confirmed Resident #72 did not have a sling on when he left with his family member, and staff were unable to locate a sling in the resident's room. Interview on 02/20/25 at 12:50 P.M. with the Administrator confirmed Resident #72 did have a sling at one point but staff were unable to locate it. 49771 3. Review of the medical record for Resident #51 revealed an admitted [DATE] with diagnoses including cerebral infarction with non-dominant (left) side hemiplegia and hemiparesis, diabetes mellitus type two, chronic kidney disease, and depression. Review of the MDS assessment for Resident #51 dated 02/09/25 revealed the resident moderately cognitively impaired and required staff assistance with ADLs. The assessment did not reflect contractures or limitations in the resident's range of motion. Review of the medical record for Resident #51 revealed neither the resident's care plan nor the diagnosis list included contractures. Observation on 02/18/25 at 10:33 A.M. revealed Resident #51's left hand was contracted. Observation on 02/20/25 at 3:57 P.M. with Rehab Director (RD) #363 revealed RD #363 found a left-hand splint in the resident's belongings on the sink counter. Interview on 02/20/25 at 3:57 P.M. with RD #363 confirmed she had been unaware Resident #51 had a contracture of his left hand. Interview on 02/20/25 at 4:00 P.M. with RN #311 confirmed the MDS assessment for Resident #51 dated 02/09/25 was inaccurate as it did not reflect contractures or limitations in the resident's range of motion. Interview on 02/20/25 at 4:10 P.M. with RD #363 confirmed Resident #51 had received therapy treatment for a left-hand contracture in September 2024.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observation and staff interviews, the facility failed to ensure residents had fluids available at bedside. This affected one Resident (#08) reviewed for hydration. The facility census was 77. Findings include Medical record for Resident #08 revealed an admission on 08/03/18 with diagnoses including but not limited to dementia with behavioral disturbances and psychotic disorders with delusions. Review of the plan of care for Resident #08 revealed the resident is currently on hospice with diagnoses of moderate protein-calorie malnutrition. Interventions include to provide and serve diet as ordered, monitor and report any signs and symptoms of pocketing, drooling, multiple attempts with swallowing and refusing to eat. Resident #08 received a mechanically altered diet with regular liquids. Review of the physician order for Resident #08 dated 08/02/23 revealed an order for regular diet, mechanical soft texture and thin liquids consistency. Review of the nutritional assessment for Resident #08 dated 06/21/24 revealed no swallowing concerns. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #08 revealed an impaired cognition. Resident #08 is set up assistance for eating, toileting, transfers and bed mobility. Resident #08 was coded with incontinence of the bowel and bladder. Observation of Resident #08 on 02/18/25 at 11:09 A.M., revealed the resident lying in bed with family at bedside. No water pitcher or cup with water at bedside. Additional observation of surrounding area revealed fluids in her room for consumption. Observation of Resident #08 on 02/19/25 at 7:35 A.M., revealed the resident lying in bed with bedside table next to bed. No fluids were available for Resident #08. Interview with Certified Nursing Assistant (CNA) #329 on 02/20/25 at 9:59 A.M., revealed Resident #08 did not have water pitcher in her room because she has a history of throwing it at staff or taking it to other resident's rooms. CNA #329 stated Resident #329 was able to drink independently. Observation of Resident #08's room on 02/20/25 at 11:00 A.M. with Director of Nursing (DON) revealed Resident #08 did not have any fluids available for consumption and she should have. Interview with Resident #08 on 02/20/25 at 11:00 A.M. with Director of Nursing (DON), revealed the resident was lying in bed without any fluids available to drink. Resident #08 was questioned if she was thirsty and if she would like something to drink and the resident responded yes, what do you have. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Administrator on 02/20/25 at 11:42 A.M, verified Resident #08 should have water available in her room at all times. The Administrator stated she was unaware staff was not providing fluids for Resident #08 related to behaviors Interview on 02/20/25 at 3:15 P.M. with Nurse Practitioner (NP) #500 stated there was no medical reason for Resident #08 to not have water at the bedside. NP #500 verified Resident #08 was currently on regular liquids and no laboratory tests were obtained regarding hydration due to hospice services in place. Request for policy related to hydration was requested during the survey and not provided for review.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, staff interview and policy review, the facility failed to ensure timely monitoring of adverse side effects of psychoactive medications. This affected three Residents (#08, #72, and #06) of the five resident reviewed for unnecessary medications. The facility census was 77. Findings include 1) Medical record for Resident #08 revealed an admission on 08/03/18 with diagnoses including but not limited to dementia with behavioral disturbances and psychotic disorders with delusions. Review of the plan of care dated 08/15/18 for Resident #08, revealed the resident takes psychoactive medication related to psychotic disorder. Interventions include administering medication as ordered, monitoring, documenting and report adverse side effects of psychotropic medications. Review of the active physician orders for Resident #08 revealed an order dated 04/17/23 for Seroquel (antipsychotic) tablet 25 milligram (mg) by mouth three times a day. Review of the facility assessment tab in the electronic health record (EHR) for Resident #08 revealed an abnormal involuntary movement (AIMS) (a rating scale used to assess the severity of involuntary movements; particularly tardive dyskinesia) was last completed on 06/19/24. Additional review of assessment tab revealed only one AIMS assessment was completed in 2024 and no AIMS assessments were completed in January or February of 2025. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #08 revealed an impaired cognition. Resident #08 was coded as receiving antipsychotic and antidepressants medications during the assessment period. Interview on 02/20/25 at 3:30 P.M. with MDS Coordinator #316, verified the AIMS assessment should be completed with the annual and quarterly assessments. MDS Coordinator #316 verified the assessments were not completed for the MDS completed on 04/30/25, 07/31/25, 10/31/25 and 01/29/25 and they should have been. 2) Medical record review for Resident #72 revealed an admission on 09/25/24 with diagnoses including schizophrenia, subdural hemorrhage, traumatic brain injury and fracture of cervical vertebra. Review of the Medication administration record (MAR) for Resident #72, revealed an order for Invega Sustenna (atypical antipsychotic) Intramuscular Suspension Prefilled Syringe 117 MG/0.75 milliliter (ml) Inject one dose intramuscularly one time a day every 30 days dated 10/10/2024. Review of the quarterly MDS assessment dated [DATE] for Resident #72, revealed the resident had an impaired cognition. Resident #72 was independent in eating, toileting, bed mobility and transfers (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care for Resident #72, revealed the resident is at risk for adverse effects and complications related to the use of psychotropic medications. Interventions include administering medications as ordered, monitoring and document for side effects and effectiveness, completing an AIMS every six months and as warranted and consulting with pharmacy, physician to consider dosage reduction when clinically appropriate. Review of the facility assessment tab in the electronic health record for Resident #72, revealed no documented evidence of any assessment for AIMS completed for the resident. Interview on 02/20/25 at 3:25 P.M. with the Director of Nursing (DON) verified the AIMS test was not completed on admission and should have been. 42731 3) Review of the medical record of Resident #06 revealed an admitted [DATE]. Diagnoses included dementia with agitation, memory deficit following cerebrovascular disease, type 1 diabetes, history of traumatic brain injury, post-traumatic stress disorder, unspecified convulsions, anxiety, depression, violent behavior, and mood disorder. Review of the physician orders for Resident #06 revealed an order dated 12/23/24 to check laboratory results (labs), including a Depakote level. The frequency of the need for the labs was not specified. Further review of physician orders revealed orders dated 01/07/22 for Depakote tablet Delayed Release (DR) 500 milligrams (mg) twice per day for unspecified convulsions and 08/01/24 for Rexulti (atypical antipsychotic) Oral Tablet two mg one time a day for dementia with agitation. Review of the quarterly MDS assessment for Resident #06 dated 01/24/25, revealed the resident had intact cognition. The resident required set-up assistance with eating, supervision for oral hygiene, toileting, bathing, dressing, bed mobility, and transfers. Review of the medical record for Resident #06, revealed no documented evidence of a Depakote level (or valproic acid level) being obtained as ordered. Review of the medical record for Resident #06, revealed the most recent AIMS was completed on 06/28/24. Interview on 02/20/25 at 2:00 P.M., Licensed Practical Nurse (LPN) #359 verified the most recent AIMS completed for Resident #06 was on 06/28/24. LPN #359 stated AIMS should be completed quarterly for residents taking antipsychotic medications. LPN #359 further verified there was no evidence in the medical record of a Depakote/valproic acid level being obtained as ordered. Interview on 02/20/25 at 2:05 P.M., LPN #303 revealed she called the lab and there were no Depakote/valproic acid results available at any time for Resident #06. Interview on 02/20/25 at 2:35 P.M., the Director of Nursing (DON) verified Resident #06 did not have any Depakote/valproic acid results completed in the facility since Resident #06 started taking the medication 01/07/22. The DON stated Depakote/valproic acid levels should be checked every six months and stated the facility did not have a policy regarding the use of Depakote. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/25 at 2:42 P.M., Nurse Practitioner (NP) #505 stated, when a resident takes Depakote, he expected Depakote/valproic acid levels to be monitored twice per year. Review of the facility policy titled, Use of Psychotropic Medication, dated 03/2025), revealed the resident's response to the medications should be monitored and documented. Residents who receive antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, and as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observation and staff interviews, the facility failed to ensure medications were stored in accordance with professional standards. This affected one Resident (#237) of four resident reviewed for medication administration. The facility was 77. Findings include: Review of the medical record revealed Resident #237 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia, tracheostomy, metabolic encephalopathy, diabetes mellitus type II, schizophrenia, bipolar disorder, opioid dependence and congestive heart failure. Review of the admission Minimum Data Set (MDS) assessment for Resident #237 dated 02/18/25 was not completed at the time of the survey. Review of the plan of care for Resident #237 was incomplete due to recent admission. Review of the physician orders for the month of February 2025 for Resident #237 revealed an order dated 02/12/25 for Lidocaine external patch 5 percent apply to affected area topically in the evening for pain. Review of the Medication Administration Record (MAR) for February 2025 for Resident #237 revealed the lidocaine patch was applied as ordered on 02/19/25 at 6:00 P.M. Observation on 02/20/25 at 9:01 A.M. of medication administration for Resident #237 with Licensed Practical Nurse (LPN) #303 and Assistant Director of Nursing (ADON) #316 revealed LPN #303 entered the resident's room with the prepared medications. Resident #237 requested LPN #303 to apply a Lidocaine patch that was observed laying on her bedside table. The Lidocaine patch was not dated and still had the protective backing adhered to one side (adhesive side) of the patch. Resident #237 stated the nurse came into her room last night (02/19/25) and did not apply the patch to her lower back as ordered. LPN #303 verified Resident #237 did not have the patch on as ordered and patch should not have been left in the room unsupervised. A request for a facility policy related to medication administration was made during the survey and not provided for review.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 42731 Based on observation, staff interview, review of a scoop size chart, and review of dietary spreadsheets, the the facility failed to ensure appropriate portion sizes were served. This had the potential to affect all 77 residents in the facility. The facility census was 77. Findings include: Observation on 02/19/25 at 11:50 A.M. revealed Dietary [NAME] (DC) #378 was utilizing a green handled scoop for serving macaroni and cheese on the lunch trayline. When queried, DC #378 was unable to say what size scoop she was using for the macaroni and cheese. Review of the dietary spreadsheet for the 2024-2025 fall/winter menus for Wednesday of week two, revealed macaroni and cheese was to be a 4 ounce (oz) serving. Review of the Portion Control Chart, as provided by the facility, revealed a green-handled scoop provided 2 and 2/3 oz and a dark gray handled scoop provided 4 oz. Interview on 02/19/25 at 12:14 P.M., Dietary Director (DD) #371 verified DC #378 was using a green-handled scoop, which provided 2 and 2/3 oz, when the spreadsheet for the meal called for a 4 oz serving, which would have required the use of a dark gray scoop.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on observation, staff interview, and policy review, the facility failed to store and handle food in a manner to prevent the potential spread of foodborne illness. This had the potential to affect all 77 residents in the facility. The facility census was 77. Findings include: 1) Observation of the dry storage area in the kitchen on [DATE] at 9:50 A.M., with Dietary Director (DD) #371, revealed a jar of grape jelly, approximately half full, with no open date, and a jug of barbeque sauce, approximately half full and with no open date. Manufacturer labels on both the jelly and barbeque sauce indicated the products needed to be refrigerated after opening. Interview at the same time with DD #371, verified the jelly and barbeque sauce were opened, partially used, not dated, and should have been refrigerated once opened. 2) Observation of the walk-in cooler on [DATE] at 9:52 A.M., revealed a plastic crate of milk cartons stored directly on the floor. Interview at the same time with DD #371 verified the milk was stored directly on the floor. 3) Observation of the walk-in freezer on [DATE] at 9:54 A.M. revealed a box of cheese stored directly on the floor. Interview at the same time with DD #371 verified the cheese was stored directly on the floor. 4) Observation on [DATE] at 9:58 A.M. revealed Dietary Aid (DA) #354 utilizing the dishwasher for cleaning dishes following the breakfast meal. Upon surveyor request, DA #354 obtained a container of sanitizer test strips and placed a test strip in the machine. Further observation revealed the container of the sanitizer test strips had an expiration date of [DATE]. Interview at the same time with DA #354, verified the test strips had expired [DATE]. 5) Observation on [DATE] at 9:11 A.M. revealed two jars of grape jelly on a shelf in the food preparation area. One jar was approximately ,d+[DATE] full and not dated. The second jar was approximately ,d+[DATE] full and dated [DATE]. The labels on both jars of jelly indicated the need to refrigerate after opening. Interview at the same time, DD #371 verified the two jars of jelly were opened, partially used, and not refrigerated. 6) Observation on [DATE] at 10:09 A.M. revealed Dietary [NAME] (DC) #378 retrieved a pan of green beans from the stove, walked to the sink in the food preparation area, and hold the pan against the inside of the sink to drain the green beans. DC #378 then took the drained green beans and added them to the Robo-coup to begin the pureeing process. Interview at the same time, DC #378 verified she drained the green beans against the inside of the sink. DC #378 stated she wipes the sink out daily, and verified the green beans touched the surface of the sink while being drained. Interview on [DATE] at 10:13 A.M., Dietary Director (DD) #371 verified draining the green beans against the inside of the sink is not considered a sanitary practice. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7) Observation of the first-floor nourishment room on [DATE] at 12:49 P.M. revealed the following: a) a plastic jar of applesauce, approximately ,d+[DATE] remaining, which was coated with a blue and fuzzy substance, and was not labeled or dated. b) a bottle of chocolate syrup, opened but not labeled or dated. c) a bottle of coffee creamer, labeled with a resident's name and dated [DATE]. d) approximately 20 meat and cheese sandwiches, individually wrapped in a non-sealable sandwich bags with no label or date. e) a one-liter plastic bottle of orange soda, approximately ,d+[DATE] full, which was not labeled nor dated. f) a sandwich, wrapped in plastic wrap, containing the numbers 105 on it with no date. g) a slice of pie on a styrofoam plate, covered in plastic wrap, with no label or date. h) a bottle of Starbucks pumpkin spice latte iced espresso, opened with a manufacturer's expiration date of [DATE], not labeled or dated. i) an open bottle of caramel sauce with no label or date. j) a can of whipped cream with no lid and no label or date. k) a cardboard to-go container containing two slices of bread and a bag of Cheetos, which was not labeled or dated. l) a plastic grocery bag containing a salad and fruit, which was not labeled or dated. m) a carton of 2% milk, unopened, dated [DATE], and bulging. n) an open can of Dr. Pepper, approximately half full, not labeled or dated. Interview at the same time with Receptionist #507, verified the plastic jar of applesauce was coated with a blue and fuzzy substance and not labeled or dated. Observation, following verification of the applesauce, Receptionist #507 took the jar of applesauce left the nourishment room and was unable to be located. Observation at the same time revealed a sign, posted on the outside of the refrigerator door, which stated, Label and Date all foods, including resident's food! All unlabeled food will be discarded! Food will be discarded after this time period: sealed beverages and sealed foods-expiration date of 7 days, resident foods (opened)-3 days, frozen foods-30 days. Interview on [DATE] at 12:58 P.M., the Administrator verified the remaining contents of the refrigerator. The Administrator further verified all contents of refrigerators should be labeled, dated, and discarded as instructed on the aforementioned sign on the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8) Observation of the second-floor nourishment room refrigerator on [DATE] at 1:02 P.M., revealed a half gallon of whole milk, with an expiration date of [DATE], partially used, with label or open date, four plastic grocery bags containing miscellaneous food items, none contained a label or date, and a clear plastic pitcher, dated ,d+[DATE] with a small amount of red liquid contents remaining on the bottom. Further observation revealed the outside door of the refrigerator had the same sign posted as was present on the first-floor nourishment room. Interview at the same time, Licensed Practical Nurse (LPN) #359 verified the contents of the refrigerator and verified all items should be labeled, dated, and discarded following expiration. Review of the facility policy titled, Food Storage, dated 2023, revealed food would be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Food should be stored a minimum of six inches above the floor. All foods should be stored off the floor in refrigerators and freezers. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within seven days or discarded. All foods should be labeled, dated, and routinely monitored to ensure foods will be consumed or discarded by their use-by dates. Review of the facility policy titled, Food Brought in from Outside Sources and Personal Food Storage, dated 2023, revealed foods and beverages brought in from outside sources that require refrigeration should be labeled with the resident's name and date. Unlabeled/undated food (s) whose date is outside the facility policy for food storage (usually seven days) can be disposed of by staff.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, staff interview, review of hospice plan of care and hospice contract, the facility failed to jointly collaborate to develop a comprehensive plan of care that identified services to be provided by both providers. This affected one Resident (#08) of two reviewed for hospice services. The facility census was 77. Findings include: Medical record for Resident #08 revealed an admission on 08/03/18 with diagnoses including but not limited to dementia with behavioral disturbances and psychotic disorders with delusions. Review of the plan of care for Resident #08 revealed resident has an advanced directive do not resuscitate comfort care (DNR-CC) order dated 02/02/2020 with a revision date of 01/30/2024. Resident #08 is currently on hospice with diagnoses of moderate protein-calorie malnutrition. Interventions included to provide and serve diet as ordered, monitor and report any signs and symptoms of pocketing, drooling, multiple attempts with swallowing and refusing to eat. Resident #08 received a mechanically altered diet with regular liquids. Review of the facility and hospice agency contract dated 01/17/2024, revealed under coordination of services facility will ensure resident's written plan of care includes the most recent hospice plan of care with descriptions of services provided by both parties. Review of the hospice agency plan of care for Resident #08 dated 11/24/24, revealed hospice services would include skilled nursing visits one to two times a week for nine weeks, an aide two times a week for nine weeks, a Chaplin and a Licensed Social Worker (LSW) as needed. Additionally, the hospice agency would provide a bedside table, hospital bed, pressure relieving mattress with bolsters, and side rails. The hospice plan of care did not indicate any collaboration with facility staff in determining services to be provided. Review of the Care Conference Form dated 12/20/24 for Resident #08 revealed no documentation of hospice staff participating in the care conference meeting. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #08, revealed an impaired cognition. Resident #08 received hospice services during the assessment period. Observation on 02/18/25 at 11:09 A.M. of Resident #08 revealed resident lying in bed with family at bedside. Interview on 02/20/25 at 9:59 A.M. with Certified Nursing Assistant (CNA) #329 stated Resident #08 has a hospice aide at times, but there is not a schedule for the facility staff to know when they will be here and what care they will provide to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365293	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Airy Gardens Rehabilitation and Nursing Center	2250 Banning Road Cincinnati, OH 45239

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/25 at 11:42 A.M with the Administrator, verified the facility has attempted to contact the hospice agency for schedule of hospice staff and services without success. The Administrator verified multiple messages have been left for the hospice agency without return contact. Interview on 02/20/25 at 12:05 P.M. with Facility's Social Service Director (SSD) #353, verified there has not been any collaboration between the facility and the hospice agency in the development of the care plan for Resident #08. SSD #353 verified a recent care conference was held on 12/20/24 and hospice staff did not participate. SSD #353 stated they were notified of the planned meeting via phone message. Interview on 02/20/25 at 2:45 P.M. with MDS Coordinator / Registered Nurse (RN) #311, verified the facility plan of care did not contain information related services hospice would be providing for Resident #08. RN #311 verified the participating hospice agency did not participate in the development of a plan of care. A request for a policy related to the development of the plan of care was requested during the survey and not provided for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure the resident bedrooms provided full visual privacy. This affected one (Residents #8) of four residents reviewed for physical environment. The facility census was 77 residents. Findings include: Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including Alzheimer's dementia, psychotic disorder with delusions, and depressive disorder. Review of the Minimum Data Set (MDS) assessment for Resident #8 dated 01/29/25 revealed the resident had severe cognitive impairment and was dependent on staff assistance with activities of daily living (ADLs). Observation on 02/18/25 at 12:29 P.M. revealed Resident #8's room window overlooked the facility parking area, and the window curtains were of a material which permitted observation from the parking lot into the resident's room. In addition, the window curtains were ripped and torn. There was no privacy curtain in the room even though privacy curtain tracking was in place. Interview on 02/20/25 at 12:50 P.M. with Housekeeping Director #341 confirmed the window curtains in Resident #8's room did not allow for visual privacy for the resident, and there was no privacy curtain in place in the resident's room. Review of the policy titled Resident Rights dated 2024 revealed the resident had a right to personal privacy in living accommodations.