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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365327 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/19/2024 |
| NAME OF PROVIDER OR SUPPLIER Montgomery Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 7777 Cooper Road Cincinnati, OH 45242 | |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069</p> <p>Based on record review, staff interview, and policy review, the facility failed to obtain authorization to manage resident funds. This affected two (#23 and #34) out of five residents reviewed for resident funds. The facility census was 60.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included flaccid hemiplegia affecting left non-dominant side, chronic obstructive pulmonary disease, type two diabetes mellitus without complications, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side, anemia, major depressive disorder, atherosclerotic heart disease of native coronary artery with other forms of angina pectoris, hyperlipidemia, anxiety disorder, vascular dementia, chronic kidney disease stage three, atrial fibrillation, congestive heart failure, iron deficiency, fibromyalgia, cerebral edema, and vitamin d deficiency.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact.</p> <p>Review of the resident funds records for Resident #23 revealed no authorization signed by the resident or the resident's representative for the facility to manage their personal funds.</p> <p>2) Review of the medical record for Resident #34 revealed an admitted [DATE]. Diagnoses included dysphagia following cerebral infarction, hemiplegia unspecified affecting right dominant side, vitamin deficiency, anemia, mixed hyperlipidemia, congestive heart failure, major depressive disorder, and sleep apnea.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #34 was cognitively intact.</p> <p>Review of the resident funds records for Resident #34 revealed no authorization signed by the resident or the resident's representative for the facility to manage their personal funds.</p> <p>Interview on 12/18/24 at 3:09 P.M. with the Administrator verified no signed authorizations to manage resident funds for Residents #23 and #34. The Administrator stated the facility was the representative payee for both residents and had not obtained authorization from the residents or their representatives.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the policy titled Deposit of Residents' Personal Funds, revised 03/2021, revealed a copy of the resident's or representative's authorization designating the facility as the agency to manage the resident's funds is filed in the resident's financial record.</p> | | |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069</p> <p>Based on record review, staff interview, and policy review, the facility failed to ensure accuracy of assessments related to hearing. This affected one (#03) of one resident reviewed for communication. The facility census was 60.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #03 revealed an admitted [DATE]. Diagnoses included unspecified sequelae of unspecified cerebrovascular disease, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, hypothyroidism, spastic hemiplegia affecting unspecified side, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side, major depressive disorder, localized edema, rhabdomyolysis, syncope and collapse, acute kidney failure, neuromuscular dysfunction of bladder, pure hypercholesterolemia, hypertension, and dysphagia.</p> <p>Review of the Minimum Data Set (MDS) assessments dated 01/30/24, 05/01/24 and 11/01/24, revealed Resident #03 was cognitively intact, had minimal difficulty with hearing and used hearing aids.</p> <p>Interview on 12/17/24 at 8:56 A.M. with Resident #03 revealed he had difficulty hearing and reported he was waiting on hearing aids. Resident #03 was observed to have trouble with hearing during the interview.</p> <p>Interview on 12/19/24 at 11:50 A.M. with Social Service Designee (SSD) #105 revealed Resident #03 had not utilized hearing aids while at the facility.</p> <p>Interview on 12/19/24 at 1:48 P.M. with MDS Coordinator/ Registered Nurse (RN) #175 revealed it was noted in Resident #03's record that he used hearing aids, which transferred over to the MDS and continued to populate on additional assessments.</p> <p>Review of the policy titled Certifying Accuracy of the Resident Assessment, revised 11/2019, revealed the information captured on the assessment reflects the status of the resident during the observation or look-back period for that assessment.</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771</p> <p>Based on review of the medical record, staff interviews, and policy review, the facility failed to ensure care conferences were completed quarterly for residents. This affected two (#14 and #20) of three residents reviewed for care conferences. The facility census was 60.</p> <p>Findings include:</p> <p>1) Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses include cerebral infarction with dominant left side hemiplegia and hemiparesis, vascular dementia and chronic kidney disease.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE], revealed Resident #20 had moderately impaired cognition.</p> <p>Review of the documentation provided by the Administrator revealed Resident #20 was offered care conferences in the first quarter (January, February and March 2024) and second quarter (April, May and June 2024) of 2024; however, the resident declined the need. A care conference was conducted for Resident #20 in the fourth quarter (October, November and December 2024) on 10/10/24 with Social Services Designee (SSD) #105 and Licensed Practical Nurse (LPN) #400. There was no documented evidence a care conference was offered or completed with the resident for the third quarter (July, August or September 2024). The Administrator verified Resident #20 did not have or was offered a care conference for the third quarter.</p> <p>Interview on 12/19/24 at 2:41 P.M. with SSD #105 verified the documentation provided by the Administrator was accurate and that the facility had not offered or conducted a care conference for Resident #20 in the third quarter of 2024.</p> <p>44412</p> <p>2) Review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, and type two diabetes.</p> <p>Review of the most recent MDS assessment dated [DATE], revealed Resident #14 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Review of the medical record revealed Resident #14 received a care conference on 10/12/23, 04/24/24, and 11/29/24.</p> <p>Review of the progress note dated 07/12/24 at 2:25 P.M. revealed Resident #14 declined the need for care conference at this time.</p> <p>Interview on 12/18/24 at 2:50 P.M. with SSD #105 verified Resident #14 did not receive a care conference in the first quarter of 2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the facility policy titled, Care Conference Procedure, dated 02/01/18 revealed the facility would meet with residents and/or their legal representative for a care conference to discuss resident care at designated times through resident's stay. A care conference shall be held at the earliest convenient time for residents and/or their legal representative after admission to facility, quarterly, prior to discharge, and as requested by facility, resident, and/or their legal representative.</p> | | |

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| <p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069</p> <p>Based on record review, staff and resident interviews, and policy review, the facility failed to timely arrange for audiology services. This affected one (#03) of the one resident reviewed for communication. The facility census was 60.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #03 revealed an admitted [DATE]. Diagnoses included unspecified sequelae of unspecified cerebrovascular disease, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, hypothyroidism, spastic hemiplegia affecting unspecified side, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side, major depressive disorder, localized edema, rhabdomyolysis, syncope and collapse, acute kidney failure, neuromuscular dysfunction of bladder, pure hypercholesterolemia, hypertension, and dysphagia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #03 was cognitively intact. The assessment also indicated Resident #03 had minimal difficulty with hearing and used hearing aids.</p> <p>Review of the assessment titled Care Conference Quarterly, for Resident #03 dated 02/05/24, revealed the resident needed to be seen by the audiologist.</p> <p>Review of the assessment titled Care Conference Quarterly, for Resident #03 dated 07/09/24, revealed the resident's power of attorney (POA) wanted the resident added to the audiology list.</p> <p>Review of the facility document titled Not Seen Visit Report dated 07/30/24 revealed Resident #03 was listed as a no show to the treatment area to see the audiologist.</p> <p>Review of an electronic mail communication dated 12/04/24 revealed Resident #03's brother sent a request for Resident #03 to be assessed for hearing aids.</p> <p>Interview on 12/17/24 at 8:56 A.M. with Resident #03 revealed he had difficulty hearing and reported he was waiting on hearing aids. Resident #03 was observed to have trouble with hearing during the interview.</p> <p>Interview on 12/19/24 at 11:50 A.M. with Social Service Designee (SSD) #105 revealed the audiologist was last at the facility on 08/29/24. SSD #105 verified Resident #03 has not been seen by the audiologist and stated the audiologist was unable to see every resident on the list and another visit was supposed to be scheduled soon after. SSD #105 reported the next audiology visit was scheduled for January 2025.</p> <p>Review of the policy titled Specialized Rehabilitation Services, revised 12/2009, revealed the facility provided specialized rehabilitative services by qualified professionals, including audiology.</p> | | |

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| <p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771</p> <p>Based on observation, record review, and staff and resident interviews, the facility failed to ensure residents received routine podiatry care. This affected four (Residents #20, #21, #2 and #14) of the four residents reviewed for podiatry services. The facility census was 60.</p> <p>Findings include:</p> <p>1) Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses of cerebral infarction with dominant left side hemiplegia and hemiparesis, vascular dementia and chronic kidney disease.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #20 had moderately impaired cognition, range of motion impairment on left upper and lower extremities and was frequently incontinent of bowel and bladder.</p> <p>Review of Resident #20's Activities of Daily Living (ADL) care plan dated 12/12/24 revealed Resident #20 had a self-care performance deficit. Interventions included total assistance with personal hygiene daily and as needed.</p> <p>Observation of wound treatment for Resident #20 on 12/17/24 at 2:15 P.M. with Licensed Practical Nurse (LPN) #400 revealed all ten of Resident #20's toenails were grossly overgrown with some curling back under the toes. Interview with LPN #400 at time of observation verified Resident #20's toenails needed to be cut. LPN #400 stated Resident #20 would be placed on the podiatry list.</p> <p>Interview on 12/18/24 at 2:40 P.M. with Resident #20 verified he would like his toenails to be cut.</p> <p>Interview on 12/18/24 at 2:50 P.M. with the Director of Nursing (DON) verified Resident #20's toenails needed cut and the resident is not diabetic. The DON revealed she was not aware of the condition of the resident's toenails and the facility staff should have provided the ADL care. Follow up interview with the DON revealed the facility does not have the equipment needed to cut the resident's toenails in their current condition and that it would have to be completed by a podiatrist.</p> <p>2) Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, dysphagia, epilepsy, neurogenic bladder, paraplegia and unspecified dementia.</p> <p>Review of the MDS quarterly assessment dated [DATE] revealed Resident #21 had moderate cognitive impairment.</p> <p>Review of Resident #21's ADL care plan dated 12/07/24 revealed Resident #21 had a self-care performance deficit. Interventions included total assistance with personal hygiene daily and as needed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Observation of Resident #21 on 12/18/24 at 4:18 P.M. revealed the resident was alert and able to respond with appropriate answers to questions. The resident had contractures in both lower extremities and the toenails on both feet were grossly overgrown, jagged and in need of nail care.</p> <p>Interview with Resident #21 at the same time, revealed he would like his toenails cut.</p> <p>Interview on 12/18/24 at 4:33 P.M. with the DON verified Resident #21's toenails were grossly overgrown, jagged and in need of nail care.</p> <p>44412</p> <p>3) Review of the medical record for Resident #02 revealed an admitted [DATE]. Diagnoses included multiple sclerosis (MS), neuromuscular dysfunction of bladder, and major depressive disorder.</p> <p>Review of the care plan dated 01/15/24 revealed Resident #02 had an ADL self-care performance deficit related to multiple sclerosis and pain. Interventions included substantial assistance with hygiene and bathing, skin inspection with care, and explain all procedures and tasks before starting.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #02 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Observation on 12/18/24 at 3:19 P.M. revealed Resident #02's toenails on the right foot were overgrown, about a quarter of an inch in length and big toenail on left foot was about a quarter of an inch and jagged.</p> <p>Interview on 12/18/24 at 3:21 P.M. with DON verified Resident #02's toenails were overgrown and needed cut.</p> <p>4) Review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), major depressive disorder, and type two diabetes.</p> <p>Review of the podiatry notes dated 08/04/23 revealed Resident #14 was to be seen again by podiatry in two to three months.</p> <p>Review of the care plan dated 03/13/24 revealed Resident #14 had an activity of daily living (ADL) self-care performance deficit related to asthma, COPD, CHF, and history of falls. Interventions included partial assistance with hygiene, explain all procedures or tasks before starting, and physical therapy and occupational therapy evaluation and treatment per physician orders.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #14 had intact cognition as evidenced by a BIMS score of 15.</p> <p>Review of the medical record revealed no current records of podiatry notes.</p> <p>Observation on 12/17/24 at 2:39 P.M. revealed Resident #14's toenails were overgrown about a quarter of an inch and jagged. Skin on feet was extremely dry and flaking.</p> <p>(continued on next page)</p> | | |

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| <p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Interview on 12/17/24 at 2:40 P.M. with Resident #14 revealed her toenails got caught on her socks and caused her discomfort.</p> <p>Interview on 12/17/24 at 2:50 P.M. with Licensed Practical Nurse (LPN) #451 verified toenails were overgrown and jagged for Resident #14. LPN #451 also verified the resident's feet had dry skin.</p> <p>Review of the facility policy titled, Care of Fingernails/Toenails, dated 02/18, revealed the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection. General guidelines stated nail care included daily cleaning and regular trimming and unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments and stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease.</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on review of the medical record, observations, interviews, and policy review, the facility failed to timely change oxygen tubing per physician orders. This affected one (#14) resident of six residents with oxygen therapy. The facility census was 60.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, and type two diabetes.</p> <p>Review of the care plan dated 11/01/22, revealed Resident #14 had oxygen therapy related to asthma, COPD, and shortness of breath (SOB). Interventions included check oxygen saturation as needed for SOB, encourage or assist with ambulation as indicated, and give medications as ordered by physician.</p> <p>Review of the physician order dated 06/27/24, revealed Resident #14 was ordered may use supplemental oxygen as needed (PRN) two liters per minute (LPM) via nasal cannula every shift for maintaining oxygen saturation greater than 90 percent (%) as tolerated.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #14 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Review of the physician order dated 11/07/24, revealed Resident #14 was ordered to change and date oxygen and nebulizer tubing weekly on Tuesday night shift.</p> <p>Observation on 12/16/24 at 10:04 A.M., revealed Resident #14's oxygen tubing was dated 11/13/24 and appeared dirty in appearance.</p> <p>Observation on 12/17/24 at 2:43 P.M., revealed Resident #14's oxygen tubing was dated 11/13/24 and appeared dirty in appearance.</p> <p>Interview on 12/17/24 at 2:45 P.M. with Licensed Practical Nurse (LPN) #251, verified oxygen tubing was dated 11/13/24 and appeared dirty in appearance.</p> <p>Review of the facility policy titled, Oxygen Administration, dated 2001 revealed the purpose of the procedure was to provide guidelines for safe oxygen administration. Staff verified there was a physician's order for the procedure and review the physician's orders for facility protocol for oxygen administration. Staff to assemble the equipment and supplies as needed.</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on review of the medical record, observation, interviews, and policy review, the facility failed to ensure eye drops were labeled with open date. This affected two (#06 and #19) of the 14 residents with ordered eye drops. The facility also failed to timely dispose of narcotics for residents who were no longer in the facility. This affected two (#213 and #214) residents of the nine residents with narcotics. The facility census was 60.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #06 revealed an admitted [DATE]. Diagnoses included glaucoma, Alzheimer's disease, and type two diabetes mellitus (DM II).</p> <p>Review of the physician order dated 02/24/22 revealed Resident #06 was ordered Brimonidine Tartrate 0.2 percent solution, instill one drop in both eyes three times a day related to glaucoma.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #06 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of five.</p> <p>Observation of the medication cart on 12/19/24 at 10:39 A.M., revealed Resident #06's Brimonidine eye drops were opened without a date.</p> <p>Interview on 12/19/24 at 10:40 A.M. with Licensed Practical Nurse (LPN) #400 verified Resident #06's eye drops were opened and not labeled with open date.</p> <p>2) Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included glaucoma, major depressive disorder, heart failure, and type two diabetes mellitus (DM II).</p> <p>Review of the physician order dated 03/17/22 revealed Resident #19 was ordered Dorzolamide-HCl-Timolol Mal Solution 22.3-6.8 milligrams (mg) per milliliter (ml), instill one drop in both eyes two times a day related to glaucoma.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #19 had intact cognition as evidenced by a BIMS score of 15.</p> <p>Observation of the medication cart on 12/19/24 at 10:06 A.M. revealed Dorzolamide-HCl-Timolol Mal Solution 22.3-6.8 mg/ml did not have an open date on the bottle.</p> <p>Interview on 12/19/24 at 10:07 A.M. with Registered Nurse (RN) #185 verified there was no open date on Resident #19's eye drops Dorzolamide-HCl-Timolol Mal Solution 22.3-6.8 mg/ml.</p> <p>3) Review of the medical record for Resident #213 revealed an admitted [DATE] with a discharge date of [DATE]. Diagnoses included major depressive disorder, alcohol abuse with intoxication, insomnia, chronic obstructive pulmonary disease (COPD), and acute kidney failure.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365327 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/19/2024 |
| NAME OF PROVIDER OR SUPPLIER Montgomery Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 7777 Cooper Road Cincinnati, OH 45242 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the physician order dated 07/19/24 with a discontinue date of 07/19/24 revealed Resident #213 was ordered Restoril 30 mg, give one capsule by mouth at bedtime related to insomnia.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #213 had intact cognition as evidenced by a BIMS score of 15.</p> <p>Observation of the medication cart on 12/19/24 at 10:12 A.M. revealed Resident #213's Restoril 15 mg was in the narcotic box inside the medication cart.</p> <p>Interview on 12/19/24 at 10:13 A.M. with RN #185 verified Resident #213 was not a current resident in the facility and the resident's Restoril was still being stored in the medication cart.</p> <p>4) Review of the medical record for Resident #214 revealed an admitted [DATE] with a discharge date of [DATE]. Diagnoses included traumatic subdural hemorrhage, type two diabetes mellitus (DM II), and major depressive disorder.</p> <p>Review of the physician order dated 12/11/24 revealed Resident #214 was ordered Lorazepam 0.5 mg, give 0.5 mg by mouth every four hours as needed (PRN) for anxiety.</p> <p>Review of the physician order dated 12/13/24 revealed Resident #214 was ordered Lorazepam 0.5 mg, give one mg by mouth every two hours PRN for anxiety.</p> <p>Review of the physician order dated 12/13/24 revealed Resident #214 was ordered Morphine Sulfate oral solution 100 mg / five ml, give 0.5 ml by mouth every two hours PRN for severe pain.</p> <p>Observation of the medication cart on 12/19/24 at 10:16 A.M. revealed Resident #214 had Lorazepam 0.5 mg, Lorazepam 1 mg, and Morphine sulfate in the narcotic box inside the medication cart.</p> <p>Interview on 12/19/24 at 10:18 A.M. with RN #185 verified Resident #214 was not a current resident in the facility.</p> <p>Interview on 12/19/24 at 12:14 P.M. with the Director of Nursing (DON) verified nurses should be notifying the unit manager when residents discharge from the facility to dispose of narcotics.</p> <p>Review of the facility policy titled, Discarding and Destroying Medication, dated 2001 revealed all unused controlled substances were retained in a securely locked area with restricted access until disposed of. Schedule two, three, and four controlled substances were disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications.</p> | | |