

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2024
NAME OF PROVIDER OR SUPPLIER  Garden Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3536 Washington Ave Cincinnati, OH 45229	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43062</p> <p>Based on observations, staff and resident interviews, and review of facility policy, the facility failed to ensure a clean, safe, comfortable environment for all residents This affected all 46 residents who resided in the facility. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #27 revealed the resident was admitted to the facility on [DATE]. Diagnoses included acute cerebrovascular insufficiency, peripheral vascular disease, obesity, diabetes mellitus, major depressive disorder, essential primary hypertension, and atopic neurodermatitis. The record Revealed #27 had moderately impaired cognition.</p> <p>Review of the medical record for Resident #25 revealed the resident was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure with hypoxia, epilepsy, essential primary hypertension, depression, insomnia, and pneumonia. The record revealed Resident #25 was cognitively intact.</p> <p>Review of the medical record for Resident #24 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cellulitis, asthma, obstructive sleep apnea, bipolar disorder, amnesia, anemia, congestive heart failure, chronic obstructive pulmonary disease, and diabetes mellitus. The record revealed Resident #24 was cognitively intact.</p> <p>Review of the medical record for Resident #23 revealed the resident was admitted on [DATE]. Diagnoses included anemia, bowel disease, hyperlipidemia, anxiety disorder, and depression. The record revealed Resident #23 was cognitively intact.</p> <p>Interview with the Speech Therapist (ST) #137 in the lower level on 07/23/24 at 10:21 A.M., revealed Therapy Department's office was in the lower level and the residents often came to the therapy office for treatment. ST #137 stated the residents' had access and utilized the lower level</p> <p>Interview with Activity Director (AD) #75 in the lower level on 07/23/24 at 10:27 A.M., revealed the residents' utilized the lower level for activities. AD #75 stated the facility just had a large breakfast event in the lower-level last week. AD #75 stated the facility held a game activity with a large turnout last in the lower level and planned to utilize the lower level even more.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation of the lower level (a common area for the residents to congregate in, Therapy Department, Activities Department, a bathroom for men and a bathroom for women) during the initial tour on 07/23/24 from 10:38 A.M. to 10:44 A.M. with the Administrator, revealed the following:</p> <ul style="list-style-type: none"> <li>a) The area near the elevator where residents exited the elevator and entered the lower level was very dark and no overhead lights were on.</li> <li>b) The women's bathroom had a sign on the door noting it was out of order.</li> <li>c) There were numerous missing and/or broken ceiling tiles, and yellowish discolored ceiling tiles.</li> <li>d) Cobwebs, dust and debris in the windowsills and in the corners of the walls.</li> <li>e) Dead bugs throughout the floor.</li> <li>f) One two by four-foot ceiling light cover was hanging down from the brackets with exposed wires, burnt looking areas on the inside of the frame and the light was not functional. There was a hand-written paper lying on the floor under the light switch which read Do Not Use.</li> <li>g) The exit enclosure leading to the exterior, back of the building had numerous cobwebs, dirt, debris throughout the floor and the corners of the wall and the two vertical windows on the side of the door were broken.</li> <li>h) Immediately outside the exterior door, were Styrofoam food containers and other trash/debris on the ground.</li> <li>i) There was an unsecured storage area under the emergency stairs for the second and third floor with Christmas decorations and other boxes sitting on the floor. There was a broken sink vanity, a broken light fixture, broken medicine cabinet, a copper water line extending out from the wall and an open drainage sewage pipe where a toilet once was sitting.</li> <li>j) There was a broken electric steam table sitting in the middle of the floor near the entrance to the storage area.</li> <li>k) Three bedside commodes being stored right outside the therapy room.</li> </ul> <p>Interview with the Administrator at the same time verified the findings above. The Administrator stated the light where the cover was hanging down was not functional due to a short from a water leak and the light was turned off due to a safety hazard and the Maintenance Department was working on it. The Administrator was observed to flip the switch on, and the light came on along with the lights near the elevator. The Administrator turned the light off, picked up the paper sign and re-taped it over the last two light switches. The Administrator stated they were in the middle of a renovation project.</p> <p>Observation of the 200-hall during the initial tour on 07/23/24 from 10:46 A.M. to 11:05 A.M. with the Administrator, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>a) Dead bugs in the ceiling light fixtures in the hallway near Residents #27 and #28's room.</p> <p>b) The ceiling light outside Resident #35 and #36's room was missing a light cover.</p> <p>b.) No permanently affixed handrails to the walls throughout the unit.</p> <p>c) The 200-hall shower/bathroom had broken/missing floor and wall tiles, had standing water in the floor, dark looking discoloration throughout the shower/bathroom, consistent with the appearance of mold, soiled wet towels in the floor, trash debris in the floor, the mobility grab bars were heavily rusted, and wall mirror around the sink had chipped broken pieces missing.</p> <p>d) Residents' #22, #23, #24, #25, #26, and #27's window frames, were heavily damaged from water leaking around them. Residents had towels lying in the windowsills to soak up the water when it rained.</p> <p>Interview with the administrator at the same time, verified the findings in the 200-hall. Observation at the same time, revealed Maintenance Supervisor (MS) #205 was called to the floor to inspect the light fixture. When MS #205 opened the light fixture, numerous dead bugs fell out of the light fixture and onto the floor. The Administrator noted he needed to order some handrails. The Administrator confirmed Residents' #22, #23, #24, #25, #26, and #27's windows were affected by leaking roof and the entire roof needed to be replaced.</p> <p>Observation of the 100-hall which lead into the main dining during the initial tour on 07/23/24 from 11:06 A.M. to 11:13 A.M. with the Administrator, revealed the following:</p> <p>a) The hallway was painted several different colors including patch paint throughout the hall and holes in the walls.</p> <p>b) Yellowish discolored ceiling tiles in the hallway and dining room.</p> <p>c) Missing/broken ceiling tiles with dirt/dust in the ceiling area directly over where residents eat.</p> <p>d) Ceiling light fixtures were missing the covers.</p> <p>e) The air vents in the dining room were covered in dust</p> <p>f) One window in the dining room had a large plastic tarp covering the window.</p> <p>g) Two windows leading outside where residents smoke, had cracks in the glass extending across the window.</p> <p>Interview with the Administrator at the same time verified the findings in the 100-hall and dining room.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation of the kitchen area where trays were being processed on 07/24/24 at 11:14 A.M. with Dietary Aide (DA) #101, revealed the kitchen staff were actively pouring juice into cups on the counter and directly above the tray of drinks, were several missing ceiling tiles exposing dust in the ceiling. The ceiling light fixture over the food preparation area had several small brown debris in the light fixture which appeared to dead bugs. DA #101 confirmed the ceiling tiles over the counter where food was prepared was missing, exposing dust and the lights over the kitchen preparation area contained small brown items consistent with dead bugs.</p> <p>Observation of the 300-hall (secured behavior unit) during the initial tour on 07/23/24 from 11:20 A.M. to 11:38 A.M. with the Administrator, revealed the following:</p> <p>a) The 300-hall shower/bathroom had broken/missing floor and wall tiles, dark looking discoloration throughout the shower/bathroom, consistent with the appearance of mold, and two ceiling light fixtures that were in disrepair.</p> <p>b) The dining /activities room had numerous missing floor tiles at the entrance to the room and under the sink, standing water under the sink and the sink (identified as a handwashing area for residents) had no hot water.</p> <p>Interview at the same time with the Administrator verified the findings.</p> <p>Interview with State tested Nursing Assistant (STNA) on 07/23/24 at 11:25 A.M., stated the residents on the third floor utilized the common area for dining and activities. STNA #76 confirmed the hot water at the sink did not work. STNA #76 confirmed the sink was leaking onto the floor, tiles were missing and noted been like this for awhile.</p> <p>Interview with Resident #27 on 07/23/24 at 11:51 A.M., revealed the blanket lying in her windowsill was due to her window leaking water into the room when it rained. Resident #27 stated the window leaked due to the roof. Observation at the same time, revealed bath blankets placed along the windowsill and stretched from side-to-side. The blankets were dirty, and when the blanket was lifted, there was dirt/debris under the blanket along the windowsill. The top of the window is heavily damaged, yellowish/brown staining which appears to be rust and peeling paint across the top of the window. Resident #27's room had dirt/debris and trash lying on the floor. Resident #27 stated the window had been like this for a while</p> <p>Interview with Resident #25 on 07/23/24 at 11:57 A.M., revealed water would puddle along her floor when it rained. Resident #25 stated the roof was bad and thought the facility was getting it repaired. Observation at the same time revealed blankets situated along the windowsill, and the top of the window framing was heavily damaged and yellowish/brown staining which appeared to be rust. Resident #25 stated the window had been like this for a long time.</p> <p>Interview with Resident #24 on 07/23/24 at 12:08 P.M., revealed water would puddle along her floor when it rained. Observation at the same time revealed blankets situated along the windowsill, and the top of the window framing was heavily damaged and yellowish/brown staining which appeared to be rust.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with Resident #23 revealed on 07/23/24 at 12:11 P.M., revealed her window leaked when it rained, and the staff put the blankets and/or towels in/around the window when it rained. Resident #23 stated the water would also puddle onto the floor when it rained. Observation at the same time, revealed the top of the window frame was heavily damaged and rusted, dirt/debris in the windowsill, two full trash bags with trash sitting on the floor, wet bath blankets wadded up behind the resident's headboard and the bed was pulled away from the wall. Resident #23 stated the window leaked when it rained, the bed was moved away from the wall due to the water leaking and the trash bags and wet blankets were from the rain a few days ago. Resident #23 stated the window had been like this for a while</p> <p>Interview with Assistant Director of Nursing (ADON) #131 on 07/23/24 at 12:13 P.M., confirmed Resident #23's window had heavy water damage along the top of the window. ADON #131 confirmed Resident #23's head board of the bed would normally meet the wall with the window next to it; however, it was pulled out and away from the wall. ADON #131 confirmed two large full trash bags and bath blankets were stuffed between the headboard and the wall with the water damaged window.</p> <p>Interview with STNA #91 on 07/23/34 at 12:20 P.M. confirmed Residents #24 and #27's window was damaged along the top of the window and had blankets in the window to soak up water.</p> <p>Interview with the Administrator on 07/23/24 at 12:30 P.M., revealed the facility was attempting to secure a Housing and [NAME] Development (HUD) loan for all the repairs. The Administrator noted an inspector recently completed an inspection of the facility on 06/06/24 and provided the facility with the long list of immediate, short term (less than one year) and long term (less than [AGE] years) repairs that needed to be completed.</p> <p>Interview with STNA #91 on 07/23/24 at 2:20 P.M., confirmed the water damage all along the top of Resident #25's window along with the bath blankets across the windowsill. STNA #91 confirmed the ceiling light fixture to the right of Resident #25's bed was missing a cover.</p> <p>Review of facility policy titled Quality of Life -Homelike Environment revealed residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00156054, OH00155202, and OH00155184.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43062</p> <p>Based on observations, staff interview, and review of facility policy, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This had the potential to affect all 46 residents who resided in the facility.</p> <p>Findings include:</p> <p>Observation of the kitchen on 07/24/24 at 11:30 A.M. with Dietary Manager (DM) #110, revealed the trash cans located in the kitchen had a build-up of food debris and splatter running down the sides of the container and did not contain a lid. The wall tiles located along the length of the three-compartment sink and extending up the walls contained an unknown black substance which appeared to be consistent with mold. Interview with DM #110 at the same time confirmed the findings in the kitchen.</p> <p>Observation of the tray service line on 07/24/24 at 11:55 A.M., revealed Dietary [NAME] (DC) #109 began the tray line by taking the food temperatures. DC #109 took the food thermometer and placed it directly into the broccoli that measured 270 degrees Fahrenheit (F), then placed the thermometer into the pork stir fry that measured 196 degrees F, then placed the thermometer into the hamburger patty with a reading of 161 degrees F then placed the thermometer into the rice and it measured 181 degrees F. DC #109 confirmed that at no time did he sanitize the food thermometer before he started taking the food temperatures or between the food items.</p> <p>Review of the facility policy titled, Sanitation of Dietary Department, dated 06/2016, revealed the dietary staff shall maintain the sanitation of the dietary department through compliance with a written, comprehensive cleaning schedule.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43062</p> <p>Based on observations, staff interviews, record review, review of local Health Department records, and review of facility policy, the facility failed to maintain equipment in safe operating condition. This affected two (#24 and #27) of the five residents reviewed for beds /equipment. The facility also failed to ensure the dishwasher was maintained in working order. This had the potential to affect all 46 residents who resided in the facility.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #24 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cellulitis, asthma, obstructive sleep apnea, bipolar disorder, amnesia, anemia, congestive heart failure, chronic obstructive pulmonary disease, and diabetes mellitus.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #24 was cognitively intact, was independent with bed mobility and required supervision with transfers.</p> <p>Interview with Resident #24 on 07/23/24 at 12:08 P.M., revealed the bottom of her bed was broken and falling to the floor which caused the foot of her mattress to flip up. Observation at the same time revealed the bottom frame was twisted and mattress was not properly aligned on the bed.</p> <p>Interview with State tested Nurse Aide (STNA) #91 on 07/23/24 at 12:20 P.M., verified Resident #24's bed appeared to be broken. STNA #91 confirmed the footboard was pushed toward the floor and one side of the mattress was flipped forward. Observation revealed STNA #91 attempted to fix the foot board and frame so the mattress would not flip up; however, STNA #91 was unsuccessful.</p> <p>2) Review of the medical record for Resident #27 revealed the resident was admitted on [DATE]. Diagnoses included acute cerebrovascular insufficiency, peripheral vascular disease (PVD), obesity, diabetes mellitus, major depressive disorder, gastro-esophageal reflux disease (GERD), essential primary hypertension, and atopic neurodermatitis.</p> <p>Review of the most recent MDS assessment dated [DATE], revealed Resident #27 had moderately impaired cognition and required assistance from staff with transfers.</p> <p>Observation of Resident #27's bed 07/23/24 at 11:51 A.M, revealed the bed's white electrical cord had been spliced, attached to a black cord using wire nuts and electrical tape and plugged into a damaged outlet. The receptacles in the outlet were pushed into the wall and there was a screw inside one of the receptacles ground terminal. Interview with Resident #27 at the same, revealed she was not aware of the bed's electrical cord having electrical tape and wire nuts joining the two cords together. Resident #27 stated her bed wouldn't go up and down and maintenance was supposed to fix it. Observation at the same time revealed the bed would not go up and down.</p> <p>Interview with STNA #91 on 07/23/24 at 2:20 P.M. confirmed Resident #27's electrical cord for her bed, was connected together to another cord with electrical tape. STNA #91 stated the bed would not move up or down and she needed the bed to be moved up and down to provide personal care to Resident #91.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with Maintenance Supervisor (MS) #205 on 07/23/24 at 2:35 P.M., revealed he took two different cords and joined them together with wire nuts and covered with the electrical tape over in order to get Resident #27's bed to work. MS #205 stated he determined this is was safe because he consulted with an electrician. MS #205 stated he received a call in the middle of the night from the nursing staff about a week ago because they could not get Resident #27's bed to work. MS #205 stated this was a temporary fix until he could order the appropriate cord.</p> <p>3) Observation of the kitchen with Dietary Manager (DM) #110 on 07/24/24 at 11:30 A.M., revealed the dishwasher's thermostat gauge was not functional. DM #110 stated a new gauge had been on order for an unknown time. DM #110 stated she utilized a food thermometer to test the water temperatures in the dishwasher. DM #110 stated the dishwasher is a low temperature dishwasher with sanitization, so it should reach 120 degrees Fahrenheit (F) for both wash and rinse. Observation of the manufacturing tag located on the dishwasher stated the wash and rinse cycles should reach 120 degrees F. Observation revealed DM #110 ran the dishwasher for three cycles and it only reached 108 degrees F. DM #110 stated she does not have a company to routinely service the dishwasher because the Maintenance Department would provide the maintenance to the dishwashing machine in the event something happened. DM #110 stated she told the maintenance team during a morning meeting a few days ago that the dishwasher was in need of repair. DM #110 stated the dishwasher has not reached the required temperature of 120 degrees F for at least three days. DM #110 stated she just reminded the maintenance team this morning that the dishwasher was not working correctly and needed to be addressed. Observation of the July 2024 dishwasher temperature logs revealed the dishwasher was recorded at 120 degrees at every test. DM #110 stated she was not sure how her team could have logged 120 degrees F for the past three days when the dishwasher had not been reaching the correct temperatures. Observation of DM #110 performing a sanitation check on the dishwasher, revealed DM #110 took a piece of litmus paper (paper for testing the pH value) and placed it in the dishwasher rinse water. The litmus paper remained white and did not change colors to indicate any sanitization. DM #110 confirmed there was no sanitization and stated the facility's plan was to utilize the three-compartment sink for washing and rinsing all dishes until the dishwasher could be repaired. DM #110 stated she believed the tubing from the sanitizing solution to the dishwasher was messed up again since there was no sanitizer entering the dishwasher and this was a previous problem.</p> <p>Review of the most recent local Health Department Food Inspection Report, dated 10/13/23, revealed the facility was notified that the sanitizer concentration was not being monitored.</p> <p>Review of a Service Report dated 06/04/24, revealed the rinse-aid at the dishwasher wasn't dispensing, even after the maintenance team installed a new rinse pump squeeze. The new rinse-aid tube was installed but the product (sanitizer) was not pulling up through the tubing because the chemical and rotor assembly was too worn out and must be replaced. As a temporary repair, the service company added some cut-up paper business card stock into the chemical housing to help squeeze tube and pull the sanitizer and the sanitizer started pulling through the tube. The notes indicated the card stock was a temporary solution and a new chemical housing and rotor assembly needed to be ordered and replaced. The service company met with DM #110 ,reviewed the service performed the recommended the follow-up.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with the Administrator on 07/24/24 at 4:00 P.M., stated the facility ordered the parts recommended from the 06/06/24 service; however, he was not able to provide any documented evidence the parts had been ordered or the facility set up a follow-up inspection on the dishwasher according to the 06/06/24 recommendations. Routine maintenance records for the dishwasher were requested on numerous occasions, and at the time of exit, the facility wasn't able to provide any routine maintenance records for the dishwasher.</p> <p>Review of the facility policy titled, Dish Machine and Manual Ware Washing, dated 08/2017 revealed the dishes, utensils, serving ware, pots, pans, etc. will be cleaned whether by a machine or by hand in accordance to regulations set forth in Section 3717-1-04.4 of the Ohio Uniform Food Safety Code for machine ware washing, the equipment manufacturer's instructions will be followed with a low temperature (Chemical Sanitizer) Machine: not less than 120 degrees Fahrenheit wash and rinse Further review of the policy revealed food preparation equipment, dishes, and utensils must be cleaned and effectively sanitized to destroy potential disease carrying organisms and stored in a protected manner.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00156054, OH00155202, and OH00155184.</p>		

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>43062</p> <p>Based on observation and staff interview, the facility failed to ensure there were secured handrails throughout the hallway on the 200 unit. This had the potential to affect 15 (#22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #25, and #36) independently mobile residents residing on the 200-unit. The facility census was 46.</p> <p>Findings include:</p> <p>Observation of the 200-hall during the initial tour on 07/23/24 at 10:46 A.M. with the Administrator, revealed there were no handrails affixed to the walls in the unit.</p> <p>Interview with the Administrator on 07/23/24 at 10:48 A.M., verified there were no handrails affixed to the walls in the 200-hallway. The Administrator stated they have been remodeling the unit and he would have to order them.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00156054, OH00155202, and OH00155184.</p>