

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 02/03/2025
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 - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771</p> <p>Based on observation, staff interview, and review of facility policy, the facility failed to maintain a clean and safe environment. This affected 36 residents (#01, #02, #03, #04, #05, #06, #07, #08, #09, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, and #37). The facility census was 45.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #24 was admitted to the facility on [DATE]. Diagnoses of thoracic spinal fracture with paraplegia, protein-calorie malnutrition and schizophrenia.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE], revealed Resident #24 had no cognitive impairment.</p> <p>Observation during the initial tour on 01/30/25 from 5:30 P.M. to 6:15 P.M., revealed the following:</p> <ol style="list-style-type: none"> 1) Resident #24's room had dirty linen spread all over the floor; the walls had large areas that needed patched, sanded and painted; the floor tile in the area in front of the closet was stained/dirty with a dark, sticky substance; there was a wall shelf that had been removed from the wall and was leaning in the corner near the large closet; and the small closet had no cove base around the entire area of the closet. 2) The main corridor had five light fixtures just above the floor level without covers which exposed the bulb/bulb socket and wiring. 3) The main corridor handrails did not contain endcaps. <p>Interview with Resident #24 on 01/30/25 at 5:35 P.M., revealed she did not like how her room looked, especially the walls, the floor and the small closet.</p> <p>Interview with the Administrator and Maintenance Director #200 on 01/31/25 at 1:15 P.M. verified the condition of the walls, floor tile, wall shelf and cove base in the room of Resident #24; the five exposed corridor light sockets and the missing handrail end caps.</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
---	-------	-----------

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 02/03/2025
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 - Some</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 Complaint Number OH00162166.</p>		