

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
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)		
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on personnel record review, staff interview, and review of the facility policy, the facility failed to ensure Certified Nursing Assistants (CNAs) received annual performance evaluations. This had the potential to affect all of the residents residing in the facility. The facility census was 48 residents. Findings include: Review of the personnel file for Certified Nursing Assistant (CNA) #213 revealed a hire date of 03/27/23 with no performance evaluations from 03/27/24 to 08/07/25. Review of the personnel file for CNA #224 revealed a hire date of 08/29/23 with no performance evaluations from 08/29/23 to 08/07/25. Interview on 08/07/25 at 8:47 A.M. with Human Resources #202 verified the facility had not completed annual performance evaluations for CNAs #213 and #224. Review of the facility policy titled Performance Evaluations dated September 2020 revealed the job performance of each employee should be reviewed and evaluated at least annually.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on personnel record review, staff interview, and review of the facility policy, the facility failed to implement their tuberculosis (TB) control plan for tuberculosis testing of newly hired employees. This had the potential to affect all of the residents residing in the facility. Based on observation, staff interview, and review of the facility policy, the facility also failed to ensure staff practiced appropriate hand hygiene during medication administration. This affected four (#11, #31, #36, and #47) of four residents observed for medication administration. The facility census was 48 residents. Findings include: 1. Review of the personnel file for Certified Nursing Assistant (CNA) #213 revealed a hire date of 03/27/23 with no two-step TB skin test upon hire. Review of the personnel file for CNA #110 revealed a hire date of 11/01/24 with no two-step TB skin test upon hire. Review of the personnel file for Licensed Practical Nurse (LPN) #227 revealed a hire date of 09/26/24 with no two-step TB skin test upon hire. Review of the personnel file for Housekeeper #247 revealed a hire date of 05/05/25 with no two-step TB skin test upon hire. Review of the personnel file for Admissions Director #201 revealed a hire date of 03/13/23 with no two-step TB skin test upon hire. Interview on 08/07/25 at 8:18 A.M. with Human Resources (HR) #202 confirmed the facility had not conducted a TB skin test upon hire for the following employees: CNA #213, CNA #110, LPN #227, Housekeeper #247, AD #201. HR #202 confirmed the facility should conduct a two-step TB skin test on employees upon hire. Review of the facility policy titled Employee Screening for Tuberculosis dated July 2010 revealed all employees should be screened for TB infection and disease using a two-step TB skin test. 2. Observation on 08/05/25 of medication administration from 10:33 A.M. to 11:38 A.M. to Residents #11, #36, #47, and #41 per Registered Nurse (RN) #258 revealed the nurse placed the residents' medications into med cups using her bare hands. Interview on 08/05/25 at 11:40 A.M. with RN #258 confirmed she had touched Residents #11, #36, #47, and #41's medication with her bare hands prior to administration. Review of the facility policy titled Administering Oral Medications dated October 2010 revealed staff members should not touch residents' medications with their ungloved hands.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on personnel record review, staff interview, and review of the facility policy, the facility failed to ensure Certified Nursing Assistants (CNAs) received at least twelve hours of in service annually. This had the potential to affect all of the residents residing in the facility. The facility census was 48. Findings include: Review of the personnel file for Certified Nursing Assistant (CNA) #209 revealed a hire date of 05/20/80 with no documented in-service education from 05/20/24 to 08/07/25. Review of the personnel file for CNA #213 revealed a hire date of 03/27/23 with no documented in-service education from 03/27/24 to 08/07/25. Review of the personnel file for CNA #224 revealed a hire date of 08/29/13 with no documented in-service education from 08/29/23 to 08/07/25. Interview on 08/07/25 at 8:47 A.M. with Human Resources (HR) #202 confirmed the facility did not have documentation of twelve hours of annual in-service education for CNAs #209, #213, and #224. Review of the facility policy titled In-Service Training undated revealed all CNAs employed by the facility must complete a minimum of 12 hours of in-service training annually.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of facility incident investigations, resident interview, staff interview, and review of the facility policy, the facility failed to report allegations of resident-to-resident sexual abuse to the state agency within 24 hours. This affected four (Residents #2, #8, #11, #36) of four residents reviewed for abuse. The facility census was 48 residents. Findings include: 1. Review of the medical record for Resident #36 revealed an admission date of 03/22/22 with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety disorder, and osteoarthritis. Review of the Minimum Data Set (MDS) assessment for Resident #36 dated 07/03/25 revealed the resident was severely cognitively impaired and required staff assistance with activities of daily living (ADLs.) Review of the progress note for Resident #36 dated 07/12/25 at 6:12 P.M. revealed staff witnessed the resident sitting in the lap of another peer and kissing him. Staff separated Resident #36 removed them from the environment and educated the resident on personal space and understanding boundaries. Review of the behavior care plan for Resident #36 dated 07/16/25 revealed the resident had been sexually inappropriate with another male resident. Interventions included the following: administer medications as ordered, monitor and document side effects and effectiveness, assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, caregivers to provide opportunity for positive interaction, educate the resident, caregivers and families on successful coping and interaction strategies, intervene as necessary to protect the rights and safety of others and monitor behavior episodes and attempt to determine an underlying cause. Review of the medical record for Resident #11 revealed an admission date of 02/12/25 with diagnoses including radiculopathy, schizoaffective disorder, bipolar disorder, and congestive heart failure. Review of the care plan for Resident #11 dated 03/10/25 revealed the resident had altered behaviors including being verbally disruptive, resistive to care, violence, anger and noncompliance. Interventions included the following: administer prescribed medications, observe for side effects, monitor for effectiveness, allow resident to pace where he can be observed, as needed medication given after non pharmacological approach attempted, assess for internal and external contributors to rule out delirium, be careful to not invade the resident's personal space, consult with psychiatric services if needed and as requested by the resident, family and physician, convey acceptance of the resident during periods of inappropriate behavior, and encourage family support and involvement. Review of the MDS assessment for Resident #11 dated 05/21/25 revealed the resident was moderately cognitively impaired and required staff assistance with ADLs. Review of the progress note for Resident #11 dated 07/12/25 at 6:17 P.M. revealed staff witnessed a peer sitting in the resident's lap and started to kiss him. Staff separated the residents and educated Resident #1 on the importance of setting boundaries for personal space. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility SRI initiated 07/16/25 at 12:50 A.M. revealed the facility investigated an allegation of sexually inappropriate conduct which had occurred between Resident #36 and Resident #11 on 07/12/25 at 6:15 P.M. The facility did not substantiate abuse. Review of the undated facility investigation of the incident between Resident #36 and Resident #11 which occurred on 07/12/25 revealed the incident was mentioned in morning report meeting on 07/12/25 but the employee on duty was not sure if the incident needed to be reported to administration. The facility provided one-on-one coaching with the employee regarding immediate reporting of abuse allegations. Interview on 08/04/25 at 12:25 P.M. with Resident #11 confirmed the resident did not recall kissing or being kissed by any resident at the facility and the resident denied being sexually abused at the facility. Interview on 08/04/25 at 1:24 P.M. with Resident #36 confirmed the resident did not recall kissing or being kissed by any resident at the facility and the resident denied being sexually abused at the facility. Interview on 08/05/25 at 11:44 A.M with the Director of Nursing (DON) confirmed the DON saw the progress notes about Resident #11 and Resident #36 kissing on 07/12/25 when she reviewed the 72-hour report on 07/14/25. The DON reported that the staff working did not report the incident to her or other administrative staff. The DON verified that the incident occurred on 07/12/25 and an SRI was not filed until 07/16/25. Interview on 08/06/25 at 11:17 A.M. with Licensed Practical Nurse (LPN) #228 confirmed the nurse could not recall the date of the incident but stated she was called to the secured unit by Certified Nursing Assistant (CNA) #211. LPN #228 stated CNA #211 reported Resident #11 and Resident #36 were at the nurses' station and Resident #36 sat on Resident #11's lap and started to kiss him. LPN #228 stated Resident #11 and Resident #36 were separated by CNA #211 prior to LPN #228 arriving on the unit. LPN #228 confirmed the DON was notified. Interview on 08/06/25 at 11:24 A.M. with CNA #211 confirmed the aide could not recall the date of the incident, but she was coming out of another resident's room when she saw Resident #11 sitting on his rollator walker by the nurse's station. CNA #211 stated Resident #36 was standing over Resident #11 and was straddling him on his walker. CNA #211 reported Resident #36 was holding Resident #11's head and Resident #36 was kissing Resident #11 on the lips. CNA #211 confirmed she reported the incident to the nurse. 2. Review of the medical record for Resident #8 revealed an admission date of 04/06/25 with diagnoses including cirrhosis of the liver, alcohol abuse, and cocaine abuse. Review of MDS assessment dated [DATE] for Resident #8 revealed the resident had mild cognitive impairment and was independent with ADLs with minimal set-up assistance. Review of the progress note for Resident #8 dated 06/22/25 at 8:32 A.M. revealed the resident was sitting on the porch, resident smoking area, involved in sexual activity with a female resident from another unit of the facility. Both residents were physically exposed and other residents complained. The nurse explained to Resident #8 the porch was a public area and was not an appropriate place for sexual activity. Resident #8 told the nurse he would have sex anywhere he wanted and when he (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wanted and then began cursing and verbally threatening the nurse. Review of the medical record for Resident #2 revealed an admission date of 07/29/24 with a diagnosis of paraplegia. Review of the MDS assessment for Resident #2 dated 07/01/25 revealed the resident was cognitively intact and independent with ADLs. Review of the progress note for Resident #2 dated 06/22/25 at 8:30 A.M. revealed the resident was observed on the smoking porch engaged in sexual activity with another resident in the presence of other residents. The nurse explained to Resident #2 that sexual activity could not take place on the porch or other public areas, but Resident #2 laughed and stated the nurse could not stop them. Review of the facility SRIs dated 08/06/25 revealed the facility investigated an allegation of resident-to-resident sexual abuse between Residents #8 and #2. The facility did substantiate abuse. The Surveyor attempted an interview on 08/06/25 at 2:00 P.M. with Resident #8, but the resident declined the interview. Interview on 08/06/2025 at 2:51 P.M. with the Administrator confirmed staff had not reported the incident regarding Residents #8 and #2 on 06/22/25. Interview on 08/06/25 at 2:55 P.M. with the DON confirmed staff reported on 06/23/25 that Residents #8 and #2 had been kissing and talking nasty on the smoking porch on 06/22/25. The DON confirmed the facility had not investigated the incident to determine if sexual abuse had occurred nor had the facility reported the allegation immediately to the state agency as required. The DON confirmed the regional nurse told her the facility didn't have to file an SRI because the residents were consenting adults, and the residents' capacity to consent was presumed and was not investigated Review of the facility policy titled Abuse, Neglect and Exploitation dated 01/22/25 revealed the policy defined sexual abuse as nonconsensual sexual contact of any type with a resident, and the facility would report all allegations of abuse to the state agency within required timeframes. This deficiency represents noncompliance investigated under Complaint Number 2571800.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of facility incident investigations, resident interview, staff interview, and review of the facility policy, the facility failed to thoroughly and timely investigate allegations of resident-to-resident sexual abuse This affected four (Residents #2, #8, #11, #36) of four residents reviewed for abuse. The facility census was 48 residents. Findings include: 1. Review of the medical record for Resident #36 revealed an admission date of 03/22/22 with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety disorder, and osteoarthritis. Review of the Minimum Data Set (MDS) assessment for Resident #36 dated 07/03/25 revealed the resident was severely cognitively impaired and required staff assistance with activities of daily living (ADLs.) Review of the progress note for Resident #36 dated 07/12/25 at 6:12 P.M. revealed staff witnessed the resident sitting in the lap of another peer and kissing him. Staff separated Resident #36 removed them from the environment and educated the resident on personal space and understanding boundaries. Review of the behavior care plan for Resident #36 dated 07/16/25 revealed the resident had been sexually inappropriate with another male resident. Interventions included the following: administer medications as ordered, monitor and document side effects and effectiveness, assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, caregivers to provide opportunity for positive interaction, educate the resident, caregivers and families on successful coping and interaction strategies, intervene as necessary to protect the rights and safety of others and monitor behavior episodes and attempt to determine an underlying cause. Review of the medical record for Resident #11 revealed an admission date of 02/12/25 with diagnoses including radiculopathy, schizoaffective disorder, bipolar disorder, and congestive heart failure. Review of the care plan for Resident #11 dated 03/10/25 revealed the resident had altered behaviors including being verbally disruptive, resistive to care, violence, anger and noncompliance. Interventions included the following: administer prescribed medications, observe for side effects, monitor for effectiveness, allow resident to pace where he can be observed, as needed medication given after non pharmacological approach attempted, assess for internal and external contributors to rule out delirium, be careful to not invade the resident's personal space, consult with psychiatric services if needed and as requested by the resident, family and physician, convey acceptance of the resident during periods of inappropriate behavior, and encourage family support and involvement. Review of the MDS assessment for Resident #11 dated 05/21/25 revealed the resident was moderately cognitively impaired and required staff assistance with ADLs. Review of the progress note for Resident #11 dated 07/12/25 at 6:17 P.M. revealed staff witnessed a peer sitting in the resident's lap and started to kiss him. Staff separated the residents and educated Resident #1 on the importance of setting boundaries for personal space. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility SRI initiated 07/16/25 at 12:50 A.M. revealed the facility investigated an allegation of sexually inappropriate conduct which had occurred between Resident #36 and Resident #11 on 07/12/25 at 6:15 P.M. The facility did not substantiate abuse. Review of the undated facility investigation of the incident between Resident #36 and Resident #11 which occurred on 07/12/25 revealed the incident was mentioned in morning report meeting on 07/12/25 but the employee on duty was not sure if the incident needed to be reported to administration. The facility provided one-on-one coaching with the employee regarding immediate reporting of abuse allegations. The investigation did not include witness statements or witness interviews and/or staff interviews regarding the incident between Resident #11 and Resident #36 which occurred on 07/12/25. Review of the facility investigation revealed the facility interviewed seven residents related to abuse with no findings. Interview on 08/04/25 at 12:25 P.M. with Resident #11 confirmed the resident did not recall kissing or being kissed by any resident at the facility and the resident denied being sexually abused at the facility. Interview on 08/04/25 at 1:24 P.M. with Resident #36 confirmed the resident did not recall kissing or being kissed by any resident at the facility and the resident denied being sexually abused at the facility. Interview on 08/05/25 at 11:44 A.M with the Director of Nursing (DON) confirmed the DON saw the progress notes about Resident #11 and Resident #36 kissing when she reviewed the 72-hour report on 07/14/25. The DON reported that the staff working did not report the incident to her or other administrative staff. The DON verified that the incident occurred on 07/12/25 and an SRI was not filed until 07/16/25. The DON confirmed the investigation of the incident did not start until 07/14/25. The DON reported she interviewed Resident #11 and Resident #36 after she discovered the incident on 07/14/25 but neither resident recalled the incident. The DON verified the facility did not obtain any staff statements related to the incident. Interview on 08/06/25 at 11:17 A.M. with Licensed Practical Nurse (LPN) #228 confirmed the nurse could not recall the date of the incident but stated she was called to the secured unit by Certified Nursing Assistant (CNA) #211. LPN #228 stated CNA #211 reported Resident #11 and Resident #36 were at the nurses's station and Resident #36 sat on Resident #11's lap and started to kiss him. LPN #228 stated Resident #11 and Resident #36 were separated by CNA #211 prior to LPN #228 arriving on the unit. LPN #228 confirmed the DON was notified. Interview on 08/06/25 at 11:14 A.M. with CNA #211 confirmed the aide could not recall the date of the incident, but she was coming out of another resident's room when she saw Resident #11 sitting on his rollator walker by the nurse's station. CNA #211 stated Resident #36 was standing over Resident #11 and was straddling him on his walker. CNA #211 reported Resident #36 was holding Resident #11's head and Resident #36 was kissing Resident #11 on the lips. CNA #211 confirmed she reported the incident to the nurse. 2. Review of the medical record for Resident #8 revealed an admission date of 04/06/25 with diagnoses including cirrhosis of the liver, alcohol abuse, and cocaine abuse. Review of MDS assessment dated [DATE] for Resident #8 revealed the resident had mild cognitive impairment and was independent with ADLs with minimal set-up assistance. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical review, staff interview, and review of facility policy, the facility failed to notify the Ombudsman's office of resident hospitalizations and discharges from the facility. This affected one (Resident #56) of four residents reviewed for discharges. The facility census was 48 residents. Findings include: Review of the medical record for Resident #56 revealed an admission date of 02/28/25 with diagnoses including encephalopathy, opioid use, and chronic viral hepatitis C and a discharge date of 03/20/25. Review of the Minimum Data Set (MDS) assessment for Resident #56 dated 02/28/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs). Review of the medical record for Resident #56 revealed it did not include documentation of Ombudsman notification of the resident's hospitalization and discharge from the facility. Interview on 08/07/25 at 9:17 A.M with the Administrator confirmed the facility did not notify the Ombudsman of Resident #56's discharge from the facility on 03/20/25. Review of the facility policy titled Transfer or Discharge, Facility - Initiated dated on October 2022 revealed the facility was to provide notice of transfer to long term care Ombudsman as soon as practicable.		

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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** Based on medical record review, observation, resident staff interview, and review of the facility policy, the facility failed to ensure resident Minimum Data Set (MDS) assessments were accurately coded for falls and contractures. This affected one (Resident #31) of 14 residents reviewed for MDS assessment accuracy. The facility census was 48 residents. Findings include: Review of the medical record for Resident #31 revealed an admission date of 04/07/25 with diagnoses including type two diabetes mellitus, chronic kidney disease, depression, and spastic hemiplegia. Review of the progress note for Resident #31 dated 04/10/25 at 6:07 P.M. revealed the resident had a fall on the floor near the bed. Review of the interdisciplinary team (IDT) progress note for Resident #31 dated 04/11/25 revealed the resident was found on the floor on 04/10/25. Resident #31 stated he fell attempting to self-transfer himself to his wheelchair. Review of the Minimum Data Set (MDS) assessment for Resident #31 dated 04/14/25 revealed the resident had no falls since admission and had no impairment of the upper extremity including the shoulder, elbow, wrist and hand that interfered with daily functions or placed the resident at risk for injury. Review of the progress note for Resident #31 dated 04/15/25 at 11:19 A.M. revealed the resident was found kneeling on the floor in front of the toilet in the bathroom. Resident #31 stated he was trying to use the bathroom. Review of the IDT progress note for Resident #31 dated 04/16/25 revealed the resident fell on [DATE] and was found kneeling in front of his toilet. Review of the progress note for Resident #31 dated 06/01/25 at 9:27 P.M. revealed resident's left index finger was red and swollen. Resident #31 reported he fell in the shower room and staff obtained orders for an x-ray on the left hand. Review of the IDT progress note for Resident #31 dated 06/02/25 revealed the resident had an unwitnessed fall in the shower room on 06/01/25. Review of the progress note for Resident #31 dated 07/10/25 at 12:31 P.M. revealed the resident had an unwitnessed fall out of bed which resulted in a skin tear. Review of the IDT progress note for Resident #31 dated 07/11/25 revealed the resident fell out of bed on 07/10/25 when trying to reposition himself. Review of the MDS assessment for Resident #31 dated 07/15/25 revealed the resident was cognitively intact, required staff assistance with activities of daily living (ADLs), had one fall with injury since the MDS dated [DATE], and had no impairment of the upper extremity including the shoulder, elbow, wrist and hand that interfered with daily functions or placed the resident at risk for injury. Observation on 08/04/25 at 11:47 A.M. of Resident #31 revealed the resident's left hand second digit was crossed over the third digit and the resident was not able to extend his third and fourth digits. Interview on 08/04/25 at 11:47 A.M. with Resident #31 confirmed the resident sustained an injury to his left hand prior to admission which had caused a contracture to the left hand which had been present during the resident's entire stay at the facility. Interview on 08/06/25 at 12:15 P.M. with the Director of Nursing (DON) confirmed Resident #31 admitted to the facility with a previous hand fracture that caused a hand deformity. The DON verified the facility did not have any documentation of the previous hand injury nor did the facility have a care plan for Resident #31's left hand deformity. Interview on 08/06/25 at 12:28 P.M. with MDS Licensed Practical Nurse (LPN) #260 verified Resident #31's 04/14/25 and 07/15/25's MDS were not accurately coded for falls. MDS LPN #260 confirmed Resident #31's fall on 04/11/25 was not reflected on the resident's 04/14/25 MDS. MDS LPN #260 also confirmed Resident #31's 07/15/25 MDS was inaccurately coded because it indicated the resident #31 had one fall but the resident had three falls that occurred on 04/15/25, 06/01/25, and 07/10/25. Interview on 08/06/25 at 1:30 P.M. with Director of Therapy (DOT) #261 verified Resident #31 had a partial contracture of the left hand. DOT #261 confirmed Resident #31's second digit was crossed over his third digit and Resident #31 was not able to extend his third and fourth digits on his left hand. DOT #261 confirmed the facility did not have any documented therapy notes, assessments or recommendations for the contracture to Resident #31's left hand. Interview on 08/06/25 at 1:41 P.M. with MDS Licensed Practical Nurse (LPN) #260 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Garden Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3536 Washington Ave Cincinnati, OH 45229	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the MDS assessments for Resident #31 dated 04/14/25 and 07/15/25 were not correctly coded regarding the resident's left-hand contracture. Review of the facility policy titled Certifying Accuracy of the Resident assessment dated [DATE] revealed any person completing a portion of the MDS assessment must sign and certify the accuracy of that portion of the assessment.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on medical record review and staff interview, the facility failed to accurately complete the Pre-admission Screening and Resident Review (PASARR) for newly admitted residents. This affected one (Resident #11) of two residents reviewed for PASARR completion. The facility census was 48 residents. Findings include: Review of the medical record for Resident #11 revealed an admission date of 02/12/25 with diagnoses including radiculopathy, schizoaffective disorder, bipolar disorder, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 05/21/25 revealed the resident was moderately cognitively impaired and required staff assistance with activities of daily living (ADLs). Review of the PASARR for Resident dated 01/17/25 revealed the resident's diagnosis of schizoaffective disorder was not included on the PASARR. Interview on 08/06/25 at 8:18 A.M. with the Administrator verified Resident #11's diagnosis of schizoaffective disorder was not listed or marked on the PASARR. Interview on 08/06/25 at 9:47 A.M. with Social Services Designee (SSD) #259 verified Resident #11's diagnosis of schizoaffective disorder was not listed on the PASARR.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review, observation, resident interview, and staff interview, the facility failed to develop a care plan for a hand contractures. This affected one (Resident #31) of 14 residents reviewed for care plans. The facility census was 48 residents. Findings include: Review of the medical record for Resident #31 revealed an admission date of 04/07/25 with diagnoses including type two diabetes mellitus, chronic kidney disease, depression, and spastic hemiplegia. Review of the care plan for Resident #31 initiated 04/07/25 revealed it did not include a care plan for hand contractures. Review of the Minimum Data Set (MDS) assessment for Resident #31 dated 04/14/25 revealed the resident had no impairment of the upper extremity including the shoulder, elbow, wrist and hand that interfered with daily functions or placed the resident at risk for injury. Review of the MDS assessment for Resident #31 dated 07/15/25 revealed the resident was cognitively intact, required staff assistance with activities of daily living (ADLs), and had no impairment of the upper extremity including the shoulder, elbow, wrist and hand that interfered with daily functions or placed the resident at risk for injury. Observation on 08/04/25 at 11:47 A.M. of Resident #31 revealed the resident's left hand second digit was crossed over the third digit and the resident was not able to extend his third and fourth digits. Interview on 08/04/25 at 11:47 A.M. with Resident #31 confirmed the resident sustained an injury to his left hand prior to admission which had caused a contracture to the left hand which had been present during the resident's entire stay at the facility. Interview on 08/06/25 at 12:15 P.M. with the Director of Nursing (DON) confirmed Resident #31 admitted to the facility with a previous hand fracture that caused a hand deformity. The DON verified the facility did not have any documentation of the previous hand injury nor did the facility have a care plan for Resident #31's left hand deformity. Interview on 08/06/25 at 1:30 P.M. with Director of Therapy (DOT) #261 verified Resident #31 had a partial contracture of the left hand. DOT #261 confirmed Resident #31's second digit was crossed over his third digit and Resident #31 was not able to extend his third and fourth digits on his left hand. DOT #261 confirmed the facility did not have any documented therapy notes, assessments or recommendations for the contracture to Resident #31's left hand. Interview on 08/06/25 at 1:41 P.M. with MDS Licensed Practical Nurse (LPN) #260 confirmed the MDS assessments for Resident #31 dated 04/14/25 and 07/15/25 were not correctly coded regarding the resident's left-hand contracture.		

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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. Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to update care plans for residents who smoked cigarettes. This affected two (Residents #21 and #18) of four residents reviewed for smoking. The facility census was 48 residents. Findings include: 1. Review of medical record for Resident #21 revealed an admission date of 10/27/24 with diagnoses including multiple sclerosis, subdural hematoma, anxiety disorder, anti-social disorder, and spondylosis. Review of Minimum Data Set (MDS) assessment for Resident #21 dated 10/27/24 revealed the resident was cognitively intact and required supervision with activities of daily living (ADLs). Review of the smoking assessment for Resident #21 dated 10/27/24 revealed there was a box checked indicating the resident was to be supervised during smoking times. The assessment was unscored and did not indicate if the resident was an independent or supervised smoker. Review of the care plan for Resident #21 dated 11/26/24 revealed the resident was to be supervised during smoking times. Interview on 08/05/25 at 10:02 A.M with Resident #21 confirmed he knew of no set smoking times and that he smoked out on the smoking patio at will. Resident #21 confirmed he managed and maintained his own cigarettes and lighters and was actively rolling cigarettes during the interview. Interview on 08/06/25 at 12:33 P.M. with the Administrator confirmed the smoking assessment utilized by the facility had no mechanism for scoring to determine whether a resident was an independent smoker or required supervision for smoking. Interview on 08/06/25 at 8:24 A.M. with Activities Director (AD) #254 confirmed she completed smoking assessments for all the residents. AD #254 confirmed the assessment used by the facility did not include a scoring mechanism and she used her personal judgment to determine whether a resident was an independent smoker or required supervision. AD #254 confirmed the facility considered Resident #21 to be an independent smoker and the resident's care plan had not been updated to reflect the resident's smoking status. 2. Review of the medical record for Resident #18 revealed an admission date of 06/26/25 with diagnoses including chronic obstructive pulmonary disease (COPD) and acute respiratory failure. Review of the smoking assessment for Resident #18 dated 06/26/25 revealed the assessment was unscored and it was not clear if the resident was to be an independent or supervised smoker. Review of Resident #18's care plan dated 06/26/25 revealed the resident was at risk of complication/injuries related to use of tobacco with a preference to smoke cigarettes. The only intervention was for staff to assist the resident to smoking areas as needed. Review of MDS assessment for Resident #18 dated 07/02/25 revealed the resident had mild cognitive impairment. Interview on 08/07/25 at 8:26 A.M. with AD #254 confirmed the smoking assessment for Resident #18 (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was unscored and did not clearly indicate whether or not the resident was to be supervised or independent. AD #254 confirmed Resident #18 was on oxygen and required assistance of staff to remove the tubing prior to smoking, light the resident's cigarettes, and hold the cigarettes due to the resident's hand tremor. AD #254 confirmed Resident #18's smoking care plan had not been updated with interventions for safe smoking. Review of facility policy titled Resident Smoking and Electronic Cigarette Use Policy undated revealed residents would be assessed to determine their ability to smoke safely and this information would be included in the resident's care plan.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to provide appropriate hand and nail hygiene for dependent residents. This affected one (Resident #15) of four residents reviewed for hand and nail care. The facility census was 48 residents. Findings include: Review of medical record for Resident #15 revealed an admission date of 12/28/23 with diagnoses including included cerebral infarction, diabetes, hypertension, and aphasia. Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 02/13/25 revealed the resident had moderately impaired cognition and required staff assistance with bathing and personal hygiene. Observation on 08/06/25 at 8:44 A.M. of Resident #15 revealed the resident communicated via an iPad but had difficulty using the device because his fingernails were too long. The resident's nails also had debris underneath them. Interview on 08/06/25 at 8:47 A.M. with Resident #25 confirmed his nails were too long and staff had not offered to cut them, and the length of the nails made it difficult for him to use his communication device. Interview on 08/07/25 at 9:49 A.M. with the Director of Nursing (DON) confirmed nail care was to be done in conjunction with showers which were offered, at minimum, twice weekly to each resident. The DON confirmed there was no set schedule for hand or nail care outside the bathing schedule. Interview on 08/07/25 at 10:31 A.M. with Assistant Director of Nursing (ADON) #235 confirmed nail care should be occurring on shower days. Nurses were instructed to do the nail clipping of any resident who is diabetic. ADON #235 confirmed Certified Nursing Assistants (CNAs) should be charting if residents refused nail care or personal hygiene. Interview on 08/07/25 at 10:48 A.M. with Licensed Practical Nurse (LPN) #231 confirmed Resident #15 was in need of nail care to his hands due to the length of the nails and the dirt under his fingernails. Review of facility policy titled Care of Fingernails/Toenails dated October 2010 revealed nail care includes daily cleaning and regular trimming to prevent skin problems around the nail bed. This deficiency represents noncompliance investigated under Complaint Number OH00166418 (IQIES 1339328)		

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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. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to provide treatment for a resident contractures. This affected one (Resident #31) of two residents reviewed for limited range of motion and contractures. The facility census was 48 residents. Findings include: Review of the medical record for Resident #31 revealed an admission date of 04/07/25 with diagnoses including type two diabetes mellitus, chronic kidney disease, depression, and spastic hemiplegia. Review of the care plan for Resident #31 initiated 04/07/25 revealed it did not include a care plan for hand contractures. Review of the Minimum Data Set (MDS) assessment for Resident #31 dated 04/14/25 revealed the resident had no impairment of the upper extremity including the shoulder, elbow, wrist and hand that interfered with daily functions or placed the resident at risk for injury. Review of the MDS assessment for Resident #31 dated 07/15/25 revealed the resident was cognitively intact, required staff assistance with activities of daily living (ADLs), and had no impairment of the upper extremity including the shoulder, elbow, wrist and hand that interfered with daily functions or placed the resident at risk for injury. Observation on 08/04/25 at 11:47 A.M. of Resident #31 revealed the resident's left hand second digit was crossed over the third digit and the resident was not able to extend his third and fourth digits. Interview on 08/04/25 at 11:47 A.M. with Resident #31 confirmed the resident sustained an injury to his left hand prior to admission which had caused a contracture to the left hand which had been present during the resident's entire stay at the facility. Interview on 08/06/25 at 12:15 P.M. with the Director of Nursing (DON) confirmed Resident #31 admitted to the facility with a previous hand fracture that caused a hand deformity. The DON verified the facility did not have any documentation of the previous hand injury nor did the facility have a care plan for Resident #31's left hand deformity. Interview on 08/06/25 at 1:30 P.M. with Director of Therapy (DOT) #261 verified Resident #31 had a partial contracture of the left hand. DOT #261 confirmed Resident #31's second digit was crossed over his third digit and Resident #31 was not able to extend his third and fourth digits on his left hand. DOT #261 confirmed the facility did not have any documented therapy notes, assessments or recommendations for the contracture to Resident #31's left hand. Interview on 08/06/25 at 1:41 P.M. with MDS Licensed Practical Nurse (LPN) #260 confirmed the MDS assessments for Resident #31 dated 04/14/25 and 07/15/25 were not correctly coded regarding the resident's left-hand contracture. Review of the facility's resident mobility and range of motion policy dated July 2017 revealed residents with limited range of motion will receive treatment and services to increase and prevent a further decrease in range of motion.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure resident fall prevention interventions were in place as ordered by the physician and per the resident care plan. This affected one (Resident #31) of four residents reviewed for falls. The facility census was 48. Findings include: Review of the medical record for Resident #31 revealed an admission date of 04/07/25 with diagnoses including type two diabetes mellitus, chronic kidney disease, depression, and spastic hemiplegia. Review of the fall risk assessment for Resident #31 dated 04/10/25 revealed the resident had one to two falls in the past three months and was at risk for falls. Review of the fall care plan for Resident #31 dated 06/04/25 revealed the resident had a potential for injuries and falls related to a balance deficit and a history of falls. The intervention of adding a fall mat to the right side of the bed was added to the care plan on 07/16/25. Review of the interdisciplinary team (IDT) progress note for Resident #31 dated 07/11/25 at 3:39 P.M. revealed the resident fell on [DATE] while attempting to reposition himself in his bed and rolled out of bed. An intervention was to add a fall mat to the right side of the bed. Review of the Minimum Data Set (MDS) assessment for Resident #31 dated 07/15/25 revealed the resident was cognitively intact, required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #31 revealed an order dated 07/16/25 for a fall mat to the right side of the bed at all times when the resident was in bed. Observation on 08/05/25 at 11:31 A.M. of Resident #31 revealed the resident was lying in bed and did not have a fall mat next to his bed. Interview on 08/05/25 at 11:31 A.M. with Certified Nursing Assistant (CNA) #213 verified Resident #31 was lying in bed and the resident's fall mat was not in place. Observation on 08/06/25 at 11:26 A.M. of Resident #31 revealed the resident was lying in bed and did not have a fall mat next to his bed. Interview on 08/06/25 at 11:26 A.M. with CNA #212 verified Resident #31 was lying in bed and the resident's fall mat was not in place. Interview on 08/06/25 at 11:28 A.M. with Licensed Practical Nurse (LPN) #228 confirmed Resident #31's care plan indicated the resident was to have a fall mat to the side of his bed. LPN #228 verified Resident #31's fall mat was not in place while Resident #31 was lying in bed. Review of the facility policy titled Managing Falls and Falls Risk undated revealed the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to minimize complications from falling. This deficiency represents noncompliance investigated under Complaint Number OH00167474 (iQIES 1339329).		

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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** Based on observation and staff interview, the facility failed to ensure insulin pens were properly labeled and dated upon opening. This affected three (Residents #4, #38, #51) and had the potential to affect 11 facility-identified residents with orders for insulin. The facility census was 48 residents. Findings include: Observation on [DATE] at 4:16 P.M of medication cart #3 revealed it contained an unlabeled insulin pen with as an open date of [DATE]. Interview on [DATE] at 4:17 P.M with Assistant Director of Nursing (ADON) #235 confirmed there was an unlabeled insulin pen with an open date of [DATE] in medication cart #3. Observation on [DATE] at 4:25 P.M of medication cart #2 revealed it contained an open Lantus insulin pen for Resident #4 without an open date, an open Humalog insulin pen for Resident #51 with an open date of [DATE], a Lantus insulin pen for Resident #38 without an open date. Interview on [DATE] at 4:30 P.M with ADON #235 confirmed medication cart #2 contained Resident #4's open and undated Lantus insulin pen, Resident #51's open and expired Humalog insulin pen, and Resident #38's open and undated Lantus insulin pen. Review of facility policy titled Administering Medications dated on [DATE] revealed multi-dose medications are to be labeled with an open date and insulin pens are to be labeled with the corresponding residents' name.		