STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365652	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottingham Retirement Community	3995 Cottingham Drive Cincinnati, OH 45241

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of the freezer and refrigerator temperature logs, interview, and policy review, the facility failed to ensure food was stored and prepared under sanitary conditions. This had the potential to affect 56 out of 56 residents who eat food prepared in the kitchen. The facility identified one (Resident #08) who did not eat food by mouth. The facility census was 57.Findings Included:Observation of the dry food storage area on 02/09/26 at 6:33 P.M. revealed a package of opened, undated sandwich buns with mold growing on one of the buns. In addition, there was an opened, undated loaf of white bread. The Dietary Supervisor #132 verified the above items and discarded them.Observation of the walk-in refrigerator in the main kitchen on 02/09/26 at 6:44 P.M. revealed a loosely covered cart of pre-prepared foods with a date of 02/03/26. The cart contained five trays of individual prepared salads, a tray of individual servings of pumpkin pie, two trays of individual servings of coconut cream pie and two trays of individual dishes of pears. Located next to the cart dated 02/03/26 was an undated loosely covered smaller cart with a pan of diced ham, one container of onions, one tray of cooked omelets and one tray of uncooked bacon. On one of the shelves in the walk-in refrigerator there was an undated covered container of pre-made chili. All outdated and undated items were verified by the Dietary Director #123. Observation of the walk-in freezer in the main kitchen on 02/09/26 at 7:17 P.M. revealed an open box containing an opened, undated bag of frozen bread sticks. The opened bag of breadsticks were verified by the Dietary Director #123.Observation of the main kitchen on 02/11/26 at 10:50 A.M. revealed dirty kitchen ceiling tiles as well as three of four vents with dark dust coating much of the vent. The Dietary Supervisor #132 verified the ceiling tiles were dirty and revealed maintenance was in charge of cleaning the ceiling tiles and the vents. The Dietary Director #123 also verified the ceiling tiles were dirty and needed to be cleaned or replaced. Interview with Maintenance Director (MD) #500 on 02/11/26 at 3:25 P.M. verified the ceiling tiles and ceiling vents were dirty and needed cleaned in the main kitchen.Review of refrigerator and freezer temperature logs on 02/11/26 at 10:53 A.M. revealed missing temperature logs for the following dates: 09/25/25, 10/26/25 through 10/31/25. There were also missing temperature entries on 10/25/25. Review of facility policy titled Refrigerator/Freezer Temperature Records revealed temperatures shall be monitored on all refrigeration and freezer equipment twice daily and recorded on the Temperature Records Form.Review of facility policy titled Food Safety and Sanitation dated 2021 revealed food should be protected from contamination (dust, flies, rodents and other vermin). When food package was opened the food item should be marked to indicate the open date. This date is used to determine the discard date. The policy states that leftovers are to be used within 72 hours or discarded and that perishable food should be used prior to the use by date on the package.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure discharge summaries were completed. This affected one (#01) of one resident reviewed for discharge. The facility census was 57.Findings include:Review of the closed medical record for Resident #01 revealed an admission date of 11/07/25 and a discharge date of 02/03/26. Diagnoses included Parkinson's disease without dyskinesia with fluctuations, hyperlipidemia, atherosclerotic heart disease of native coronary artery without angina pectoris, major depressive disorder, repeated falls, bipolar disorder, cerebrovascular disease, conversion disorder with seizures or convulsions, encephalopathy, other symbolic dysfunctions, and chronic viral hepatitis B without delta-agent.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was cognitively intact. Resident #01 was assessed to require setup assistance for eating, oral hygiene, and personal hygiene, and partial/moderate assistance for toileting, bathing, dressing, bed mobility, and transfers.Review of the discharge summary for Resident #01 dated 01/30/26 revealed the assessment had not been completed, and the areas related to discharge destination, home health services, durable medical equipment, social service history, and dietary information were all blank.Review of the progress note dated 02/03/26 revealed Resident #01 discharged from the facility to the attached assisted living facility.Interview on 02/12/26 at 12:30 P.M. with the Director of Nursing (DON) verified the discharge summary had not been completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to ensure care was coordinated with the hospice provider. This affected one (#29) of three residents reviewed for hospice services. The facility census was 57. Findings include:Review of the medical record revealed Resident #29 admitted to the facility on [DATE] with diagnoses including cerebral infarction, cognitive communication deficit, aphasia, hemiplegia (right side), unspecified convulsions, stenosis of right cerebral artery, diabetes, hyperlipidemia, hypertension and history of transient ischemic attacks. Review of the Minimum Data Set (MDS) assessment, dated 11/18/25, revealed Resident #29 was moderately cognitively impaired. Further review of Resident #29's medical record revealed a referral for hospice services on 11/06/25. Review of a progress note, dated 11/12/25 and authored by Social Service Director (SSD) #214, revealed a care conference was held with Resident #29's family and they felt a hospice referral would benefit the resident once she was discharged from skilled speech therapy (ST). Resident #29's granddaughter revealed she believed the resident had already been enrolled on hospice the previous week. SSD #214 had not heard of the resident being admitted to hospice services and would follow-up to confirm. Resident #29's granddaughter could not remember the exact admission date. SSD #214 confirmed with Hospice Nurse (HN) #403 that Resident #29 elected hospice service but could not recall the exact date. HN #403 stated the hospice marketer would bring a binder with all of Resident #29's information for SSD #214 to review. SSD #214 confirmed and updated Resident #29's code status to Do Not Resuscitate-Comfort Care (DNRCC) and made necessary changes the medical record. Review of Resident #29's hospice binder revealed and initial order sheet and hospice contact information. There was no plan of care, progress notes, or other documentation of the services hospice was providing for Resident #29. Interview with Resident #29 on 02/11/26 at 8:25 A.M. confirmed hospice staff saw her at the facility but she was unable to explain who came, how often, or what services were provided by hospice staff. Interview with Registered Nurse (RN) #310 on 02/11/26 at 8:37 A.M. revealed she was unsure if Resident #29 received hospice services. RN #310 sated she had not seen hospice staff visiting Resident #29 recently. Interview with the Administrator and SSD #214 on 02/11/26 at 9:05 A.M. revealed SSD #214 did most hospice referrals, but Resident #29 was referred by the Nurse Practitioner (NP). SSD #214 confirmed she knew nothing about the referral or the resident's election of hospice benefits. SSD #214 stated the care conference on 11/12/26 was the first she had heard about the hospice referral/admission. HN #403 confirmed with SSD #214 on 11/12/25 that Resident #29 had elected hospice benefits, but was unable to confirm a date and stated a binder should be brought in with all of that information in it. SSD #214 and the Administrator were unaware there was no plan of care or progress notes from the hospice provider available at the facility. A telephone interview on 02/11/26 at 1:20 P.M. with HN #403 revealed Resident #29 received hospice nursing services every Tuesday and a hospice aide every Thursday for a shower. HN #403 stated hospice staff completed their documentation in their EMR and was unaware no documentation was available at the facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to have physician orders in place for the administration of oxygen. Additionally, the facility failed to ensure appropriate oxygen in use signage was posted. This affected one (#56) of two residents reviewed for oxygen therapy. The facility census was 57.Findings include: Review of the medical record for Resident #56 revealed an admission date of 02/14/2023. Diagnoses included multiple sclerosis, asthma, acute and chronic respiratory failure with hypoxia, morbid obesity, anxiety disorder, and major depressive disorder, recurrent, moderate.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. Review of the physician orders revealed Resident #56 did not have orders for the administration of oxygen.Observations on 02/10/26 at 10:16 A.M. and on 02/11/26 at 10:45 A.M. revealed Resident #56 was receiving oxygen at two liters per minute (lpm) via an oxygen concentrator. Further observation revealed there was no signage on Resident #56's door indicating that oxygen was in use.Interview on 02/11/26 at 10:45 A.M. with Licensed Practical Nurse (LPN) #326 confirmed Resident #56 was receiving oxygen therapy at two lpm. Further interview with LPN #326 verified there were no physician orders for oxygen and Resident #56 returned to the facility from the hospital on [DATE] on two lpm of oxygen and to wean as appropriate. Additionally, LPN #326 there was no sign on the resident's door indicating oxygen was in use.Review of the facility policy titled, Oxygen Administration, revised date of April 2023, revealed oxygen was administered under orders of a physician. Additionally, oxygen warning signs must be placed on the door of the resident's room where oxygen is in use.

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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 medical record review, observations, staff interview, and review of facility policy the facility failed to ensure medications were stored in an appropriate manner. This affected one (#11) of four residents reviewed for medication storage. The facility census was 57.Findings include:Record review for Resident #11 revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia, chronic venous hypertension, Type II diabetes, and neuropathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had minimally impaired cognition.Review of the physician orders revealed Resident #11 received the following medications: gabapentin oral capsule 300 milligrams (mg), three capsules by mouth twice daily for neuropathy and carvedilol 3.125 mg, one tablet by mouth twice daily for hypertension.Review of the Medication Administration Record (MAR) for 02/10/26 and 02/11/26 revealed Resident #11 was administered gabapentin and carvedilol as ordered. Observation on 02/11/26 at 10:15 A.M. of Resident #11's room revealed two medications on the floor beside the bed, along with an empty medication cup. The two pills and the medication cup were picked up by Assistant Director of Nursing (ADON) #300, who verified the two medications were on Resident #11's room door and further stated she would attempt to identify them. Both medications were disposed of appropriately.Interview with ADON #300 on 02/11/26 at 10:47 A.M. revealed the two pills found on the floor of Resident #11's room were identified as gabapentin and carvedilol. ADON #300 stated she could confirm which medication administration the two pills were from, but verified the medications should not have been on the floor.Review of the facility's medication storage policy, effective September 2018, revealed all medications that did not require refrigeration or freezing were to be stored in a medication cart or other designated area.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff and resident interview, and policy review, the facility failed to ensure proper enhanced barrier precautions were donned when completing a wound treatment. This affected one (Resident #17) of three residents reviewed for infection control. In addition, the facility failed to develop and implement a water management plan to mitigate the risk of Legionella. This had the potential to affect all residents residing in the facility. The facility census was 57.Findings Include:1. Resident #17 was admitted to facility on 04/28/25. Diagnoses included Alzheimer's Disease, infection of the skin, low back pain, depression, anxiety disorder, diabetes, hypertensive retinopathy, dermatochalasis, chronic kidney disease, diabetic retinopathy, and kidney transplant. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #17 was severely cognitively impaired and suffered with moderate depression. Resident #17 had an infected diabetic foot ulcer; treatments included nonsurgical dressing and ointments. Resident #17 received insulin, antianxiety medications, antidepressant medication, an anticoagulant, an antibiotic, and a hypoglycemic medication. Review of the plan of care last revision date revealed Resident #17 had a infected left foot wound, interventions included Enhanced Barrier Precautions (EBP) implemented 11/20/25. Review of the medical record for Resident #17 included an order revised on 02/03/26 for treatment of the ball of the left foot: cleanse with normal saline, apply calcium alginate cut to fit wound, cover with bordered foam dressing daily and as needed (PRN). Assess for Eschar/Black, Dark, Hard Tissue; Any Drainage/Exudate. Observation and interview on 02/11/26 at 4:25 P.M. revealed Registered Nurse #310 gathered supplies for Resident #17's dressing change, took them into the room and placed the wound supplies on the residents' bedside table. RN #310 left the bedside and closed Resident #17's door and returned to the bedside without personal protective equipment (PPE) donned and was ready to unbandage Resident #17's foot wound. RN #310 when asked by the surveyor who was in enhanced barrier precautions RN #310 stated she thought Resident #17 was. RN #310 further stated the only time staff were required to wear PPE were when they were completing direct patient care. RN #310 then asked the surveyor if the wound treatment would be considered direct patient care. RN #310 left the room at that time and returned with donned PPE. Review of facility policy titled Enhanced Barrier Precautions (EBP) dated 04/01/24 revealed EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP is indicated for residents with any wounds and require gown and gloves for high contact resident care activities. The policy goes on to say that EBP would be used with any wound care; any skin opening requiring a dressing. 2. Review of the document titled Policy and Procedure: Water Management Plan – Legionella, revised 11/18/21, revealed it was a guide on developing a water management plan, including a list of commonly used control measures. The plan did not specifically address what actions the facility was taking to reduce the risk of Legionella. Interview on 02/12/26 at 4:26 P.M. with the Administrator verified the document provided for review (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the only water management plan the facility had and was unable to provide any information related to measures used by the facility. This deficiency represents non-compliance investigated under Complaint Number 2718794.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure timely provision of a pneumococcal vaccine to a resident once consented. This affected one (Resident #19) of five residents reviewed for pneumococcal vaccine administration. The facility census was 57.Findings Include:Review of the medical record for Resident #19 revealed an admission date of 08/06/2025. Diagnoses included unspecified dementia, chronic kidney disease, type 2 diabetes mellitus without complications, and muscle weakness.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe problems with thinking and memory. The resident was set up assistance for eating, supervision assistance for ambulation, moderate assistance for oral hygiene, upper body dressing, personal hygiene, sit to stand, and transfers, and maximal assistance for toileting, bathing and lower body dressing. Resident #19 was frequently incontinent of bowel and bladder and rejected care and had wandering behaviors one to three days a week.Further record review revealed Resident #19's representatives, her son and daughter-in-law, consented on 09/24/25 for the resident to receive a pneumococcal vaccine. Continued record review on 02/12/26 for Resident #19 provided no documentation of administration of the pneumococcal vaccine to date.Interview with Assistant Director of Nursing (ADON) on 02/12/2026 at 3:39 P.M. verified Resident #19's representative consented to the pneumococcal vaccine on 09/24/2025 and that as of 02/12/26 the resident had not received the vaccine. The ADON reported that the corporate office orders vaccines from the pharmacy for residents and the ADON was unsure what had delayed the delivery and provision of this vaccine to Resident #19.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure timely provision of COVID-19 vaccine to a resident once consented. This affected one (Resident #55) of five residents reviewed for COVID-19 vaccine administration. The facility census was 57.Findings Include:Review of the medical record of Resident #55 revealed an admission date of 08/05/25. Diagnoses included nondisplaced lateral mass fracture of first cervical vertebra, subsequent encounter for fracture with delayed healing, muscle weakness, unspecified dementia, and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had moderate problems with thinking and memory. The resident was independent mobilizing in her wheelchair, setup assistance for eating, supervision assistance for sit to stand and transfers, moderate assistance for oral hygiene, toileting, bathing, upper and lower body dressing, and personal hygiene. Resident #55 was always incontinent of bladder and frequently incontinent of bowel and she did not reject care or wander.Review the medical record revealed Resident #55's representative, her daughter, consented to the COVID-19 vaccine on 09/24/25. Further review of the record revealed no indication Resident #55 had received the COVID-19 vaccination to date.Interview with Assistant Director of Nursing (ADON) on 02/12/26 at 11:14 A.M. verified Resident #55's representative had consented to the COVID-19 vaccine on 09/24/25 and as of 02/12/26 the resident had not received the COVID-19 vaccine. The ADON reported the corporate office orders vaccines from the pharmacy for residents and the ADON was unsure what had delayed the delivery and provision of this vaccine to Resident #55.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, medical record review, and review of facility policy, the facility failed to ensure call lights were functional. This affected one (#12) of three residents reviewed for call lights. The facility census was 57. Findings include:Review of Resident #12's medical record revealed he was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dysphagia, glaucoma, congestive heart failure, atrial fibrillation, heart disease, dementia without behaviors, osteoporosis, benign prostatic hyperplasia, anxiety disorder, edema, gastro-esophageal reflux disease, and hypertension.Review or Resident #12's Minimum Data Set (MDS) assessment, dated 01/05/26, revealed the resident was mildly cognitively impaired. Resident #12 utilized a wheelchair for mobility, required set-up assistance for eating, and moderate assistance with toileting, oral hygiene, dressing, and personal hygiene. Interview with Resident #12 on 02/10/26 at 2:39 P.M. revealed his call light had not been working for quite some time and he alerted staff on multiple occasions. Concurrent observation revealed Resident #12 pushed his call light and the light in the hallway did not activate to show the resident required assistance. Interview on 02/10/26 at 2:39 P.M. with Certified Nursing Assistant (CNA) #344 confirmed Resident #12's call light did not light up in the hallway to show the resident needed assistance. CNA #344 entered Resident #12's room to ensure the call light was properly plugged into the wall. CNA #344 pushed the call light again and confirmed the outside hall light was not working. CNA #344 denied being aware the resident's call light was not functioning properly but added they had not worked the last several days. CNA #344 stated they would submit a work order to get the call light repaired. Review of the facility's call light policy, dated August 2022, revealed staff were to notify maintenance if a call light was not functioning.