STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365712	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookwood Care Center	12100 Reed Hartman Highway Cincinnati, OH 45241

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 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, interview, facility policy review, and Food and Drug Administration (FDA) Food Code recommendations, the facility failed to ensure staff wore effective hair restraints while in the facility's kitchen. This failure had the potential to affect 104 residents who received meals from the kitchen. The facility census was 111. Findings included:The 2022 FDA Food Code, Chapter 2-402.11, indicated, (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.A facility policy titled, Employee Hygiene for Food Safety, dated 2023, indicated Procedure: All employees will: 1. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. An observation of the lunch meal service on 01/20/2026 at 12:23 PM revealed Dietary Aide (DA) #9 preparing bowls of fruit. The observation revealed DA #9's hair was in a ponytail down his back, and DA #9's hair was not covered with any type of hair covering. An observation on 01/20/2026 at 12:45 PM revealed DA #10 in the kitchen talking to another employee, and no hair net was observed. In an interview at that time, DA #10 stated she had a hairnet on and had just removed it a moment prior. An observation on 01/20/2026 at 12:47 PM revealed DA #10 getting a hairnet from the Director of Food Services (DFS). The observation revealed DA #10 placed the hairnet on the top of her hair with a braid uncovered down her back. An observation on 01/20/2026 at 12:56 PM revealed DA #11 unloading clean dishes from the dish machine. The observation revealed DA #11 had a hairnet on the top of his hair, with approximately four inches of hair uncovered and exposed from the bottom of the hairnet. In an interview on 01/20/2026 at 12:57 PM, DA #9 stated he usually put on a hairnet when he came into the kitchen but had forgotten to put it on that day. An observation on 01/20/2026 at 1:06 PM revealed the DFS in the kitchen with the front part of her hair uncovered by the hairnet.In an interview on 01/20/2026 at 12:58 PM, DA #11 stated that his hair in the back should also be covered with the hairnet.In an interview on 01/20/2026 at 1:00 PM, DA #10 stated she thought she just needed to cover the top part of her hair. DA #10 stated she did not know she had to cover the hair in the back. In an interview on 01/21/2026 at 12:04 PM, the DD stated staff should wear a hairnet every day, and all their hair should be covered by the hairnet. In an interview on 01/21/2026 at 12:12 PM, the Registered Dietitian stated dietary staff should ensure that all their hair was covered with the hair restraint. In an interview on 01/23/2026 at 9:00 AM, the Director of Nursing stated dietary staff needed to wear hairnets in the kitchen to protect the food from contamination. In an interview on 01/23/2026 at 9:41 AM, the Administrator (ADM) stated dietary staff should wear hairnets to prevent any contamination of the food. The ADM stated the hairnet should cover all the hair.

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on facility policy review, facility document review, observation, and interview, the facility failed to ensure residents received food in a form designed to meet individual needs during the lunch meal on 01/20/2026, which had the potential to affect the 11 residents at the facility who had a physician ordered mechanical soft diet. The facility census was 111. Findings included:An undated facility policy titled, Accuracy of Quality of Tray Line Service, indicated, All meals will be checked for accuracy by the food and nutrition services staff, and by the service staff prior to serving the meal to the individual. The policy further indicated the Procedure included, 1. The menu extensions display food items and amounts for each regular or therapeutic diet.The facility's Diet Type Report, dated 01/21/2026, revealed 10 residents with physician ordered mechanical soft diets and one resident with a pureed diet that indicated that the resident could have mechanical soft pleasure foods.The facility's lunch menu for 01/20/2026 indicated the residents on a mechanical soft diet were to receive one ground grilled ham and cheese sandwich in place of the regular grilled ham and cheese sandwich, and a 4-ounce portion of applesauce in place of the red grapes. The facility's recipe for the grilled ham and cheese sandwich indicated that for mechanical soft diets, the meat should be ground to the desired consistency. During an observation on 01/20/2026 beginning at 12:04 PM, [NAME] #12 placed food items for lunch on a steam table, including grilled ham and cheese sandwiches; however, no ground sandwiches were observed.An observation on 01/20/2026 at 1:08 PM revealed residents with a mechanical soft diet order were served whole red grapes. During an interview at the time of the observation, Dietary Aide (DA) #13 stated that sometimes the cook chopped up the dessert for the mechanical soft diets but did not do that for the grapes that day. During an interview on 01/20/2026 at 1:11 PM, [NAME] #12 stated that he served the residents with mechanical soft diets a regular sandwich because he was of the understanding that residents on a mechanical soft diet could eat a lunch meat sandwich. During an interview on 01/20/2026 at 1:23 PM, the Dietary Supervisor (DS) stated staff knew what food items to serve residents because the diet order was on the meal ticket, and any preferences were also listed on the ticket. During an interview on 01/21/2026 at 12:04 PM, the Director of Food Services (DFS) stated staff were supposed to look at the diet spreadsheet to know what to serve to residents who were on different diets. The DFS stated that residents on a mechanical soft diet should have received applesauce and ground ham and cheese sandwiches for lunch on 01/20/2026. During an interview on 01/21/2026 at 12:12 PM, the Registered Dietitian (RD) stated staff were supposed to look at the menu spreadsheet and recipes to know what to serve to residents. The RD stated residents on a mechanical soft diet should not be served grapes. The RD stated residents who were on a mechanical soft diet were due to a chewing or swallowing problem, and they needed to receive the correct diet.During an interview on 01/23/2026 at 9:00 AM, the Director of Nursing stated staff should follow the planned menu to ensure residents received the correct items if they had swallowing difficulties. During an interview on 01/23/2026 at 9:41 AM, the Administrator stated he expected the menus to be followed.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview, record review, and facility document review, the facility failed to provide the required Notice of Medicare Non-Coverage (NOMNC), Form CMS (Centers for Medicare and Medicaid Services) -10123, for 3 (Residents #80, #130, and #131) of 3 residents reviewed for Advanced Beneficiary Notice (ABN). The facility census was 111. Findings included:1. On 01/23/2026 at 8:35 AM, the Administrator stated the facility did not have a policy for beneficiary notification.The facility completed worksheet titled Entrance Conference Worksheet - Beneficiary Notice -Residents discharged Within the Last Six Months, revealed 13 residents discharged home from Medicare Part A services with benefits remaining including Resident #80, Resident #130, and Resident #131. An admission Record revealed the facility admitted Resident #80 on 08/14/2025 and the resident was discharged on 09/06/2025. According to the admission Record, the resident had a medical history that included diagnoses of malignant neoplasm of prostate, type 2 diabetes mellitus, and cognitive communication deficit.An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/2025, revealed Resident #80 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #80's SNF Beneficiary Notification Review revealed the NOMNC, Form CMS-10123, was not provided to the resident or the resident's representative prior to their discharge from the facility on 09/06/2025.2. An admission Record revealed the facility admitted Resident #130 on 10/08/2025 and the resident was discharged on 11/15/2025. According to the admission Record, the resident had a medical history that included diagnoses of cognitive communication deficit, multiple fractures of pelvis, and heart failure.A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/15/2025, revealed Resident #130 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed the start date of the resident's most recent Medicare stay was 10/08/2025 and the end date of the most recent Medicare stay was 11/14/2025.Resident #130's SNF Beneficiary Notification Review revealed the NOMNC, Form CMS-10123, was not provided to the resident or the resident's representative prior to their discharge from the facility on 11/15/2025.3. An admission Record revealed the facility admitted Resident #131 on 10/06/2025 and the resident was discharged on 12/17/2025. According to the admission Record, the resident had a medical history that included diagnoses of displaced bicondylar fracture of right tibia (shin fracture) cognitive communication deficit, and lack of coordination.A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/17/2025, revealed Resident #131 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the start date of Resident #131's most recent Medicare stay was 12/05/2025 and the end date of the most recent Medicare stay was 12/16/2025.Resident #131's SNF Beneficiary Notification Review revealed the NOMNC, Form CMS-10123, was not provided to the resident or the resident's representative prior to their discharge from the facility on 12/17/2025.During an interview on 01/21/2026 at 12:35 AM, the Administrator (ADM) stated the facility did not have Notice of Medicare Non-Coverage letters for Resident #80, Resident #130, or Resident #131.The ADM stated it was the responsibility of the previous social worker, who was no longer employed by the facility, and current staff could not locate the letters. The ADM was interviewed on 01/23/2026 at 8:35 AM and stated his expectation was that NOMNC letters were completed timely and done for all residents that had a need for them. The ADM stated the facility did not get many Medicare Part A residents, but the letters still needed to be completed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on facility policy review, record review, and interview, the facility failed to report an allegation of alleged abuse to the state agency within regulatory timeframes for 1 (Resident #35) of 2 residents reviewed for abuse. The facility census was 111. Findings included:An undated facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, indicated, Residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. The policy defined Alleged Violation as A situation or occurrence that is observed or reported by staff, resident, relative visitor or others but has not yet been investigated and, if verified, could be noncompliance with federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. The policy revealed, D. Protect the Resident included, 1. Assess the involved Resident(s), which included, a. Staff should report all incidents/allegations immediately to the Administrator or designee. The policy further indicated, E. Initial Report included, 1. Timing, which included, b. ODH [Ohio Department of Health], If Abuse is alleged or Serious Bodily Injury. If any form of abuse is alleged (e.g. [exempli gratia; for example], physical, verbal, etc. [et cetera]) or Serious Bodily Injury is identified related to any other reportable incident (e.g., Injury of Unknown Source or allegation of Neglect involving serious bodily injury), the Administrator or his/her designee will notify ODH immediately, but not later than 2 hours after the allegation is made or the serious bodily injury identified. An admission Record revealed the facility admitted Resident #35 on 06/30/2023. According to the admission Record, the resident had a medical history that included diagnoses of conversion disorder, major depressive disorder, repeated falls, and a history of traumatic brain injury.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/23/2025, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #35 did not exhibit any behaviors during the assessment period.Resident #35's Care Plan Report revealed a focus area initiated on 01/24/2024, that indicated the resident had a potential for altered mood pattern and psychosocial wellbeing related to anxiety, decreased independence, and depression.An admission Record revealed the facility admitted Resident #44 on 11/08/2023. According to the admission Record, the resident had a medical history that included diagnoses of obesity, anxiety, and paraplegia. An annual MDS, with an ARD of 10/15/2025, revealed Resident #44 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #44 had rejected care during the assessment review period but did not exhibit any other behaviors during the assessment period. The MDS indicated Resident #44 was dependent on staff for transfers and indicated that the resident used a motorized wheelchair for locomotion. Resident #44's Care Plan Report revealed a focus area revised on 02/20/2025, that indicated the need to monitor Resident #44's behavior due to a potential for altered behavior patterns, disruptive interactions, manipulative behaviors, resisting care, and noncompliance with medications. Interventions directed staff to discourage inappropriate language (initiated 02/20/2025), document each episode (initiated 12/12/2023), establish a daily routine (initiated 02/20/2025), and to explain or reinforce why behaviors were unacceptable (initiated 12/12/2023). Resident #35's Progress Notes revealed a Health Status Note, dated 11/30/2025 at 10:30 AM, that revealed Resident #35 reported that their left wrist was hurting. The note indicated Resident #35 stated their wrist was hurting because of a resident that shook their hand too hard. Per the note, Resident #35 reported that the incident occurred on 11/29/2025 at around 1:00 PM. The note indicated that the supervisor and physician were notified and an X-ray was ordered. A handwritten statement dated 12/01/2025 and signed by the Social Services Director (SSD) indicated that Resident #35 stated they were in the lobby when Resident #44 approached Resident #35 and asked to see the resident's hands. The statement indicated that when Resident #35 did not comply with the request, Resident #44 grabbed Resident #35's arms with both (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands, causing pain. Resident #35's Radiology Results Report, dated 12/01/2025, indicated that the X-ray of Resident #35's left wrist revealed no fracture or dislocation. A Sheriff's office report dated 12/02/2025 indicated that Resident #35 called in an assault report that occurred on 11/30/2025. The report indicated that the deputy spoke with the Administrator (ADM) who stated that Resident #35 reported to him that Resident #44 approached Resident #35 and asked to make Christmas decorations. Per the report, when Resident #35 declined, Resident #44 took Resident #35 by the arm and wrist and shook it and stated, I just love you. The report indicated no further action was taken due to lack of intent or maliciousness. During an interview on 01/19/2026 at 1:53 PM, Resident #35 stated that Resident #44 grabbed their wrist several months earlier, causing an injury. Resident #35 stated that they called the police and reported the incident. Resident #35 stated that they were told that Resident #44 did not have any malicious intent and was behaving out of love, not aggression, so nothing was going to be done about it. During an interview on 01/21/2026 at 2:31 PM, when resident-to-resident altercation documents were requested from the ADM, the ADM stated the only incident the facility had was when Resident #35 reported that their wrist was hurting from Resident #44 shaking their hand too vigorously, but that it was not an allegation of abuse. During an interview on 01/21/2026 at 9:55 AM, State Tested Nursing Aide (STNA) #15 stated that she was not working the day of the incident between Resident #35 and Resident #44. STNA #15 stated Resident #35 reported to her that Resident #44 had been in their wheelchair and gone by Resident #35 and grabbed Resident #35's arm. STNA #15 stated the incident had already been reported when she was told about it. During an interview on 01/22/2026 at 11:20 AM, STNA #17 stated she did not witness the incident between Resident #35 and Resident #44 on 11/29/2025. STNA #17 stated that on 11/30/2025, Resident #35 was upset and told the STNA that Resident #44 had grabbed them by the wrist the day before. STNA #17 stated she looked at Resident #35's arm and did not see any signs of injury. STNA #17 stated Resident #35 had already reported the incident to the nurse by the time it was reported to STNA #17. STNA #17 stated she had seen the ADM talking to Resident #35 within the following day or two. During an interview on 01/21/2026 at 10:50 AM, Licensed Practical Nurse (LPN) #6 stated she was not working the day of the incident, but it was reported to her during shift change that Resident #44 shook Resident #35's hand. LPN #6 stated that Resident #35 reported to her that Resident #44 shook their hand hard. During an interview on 01/22/2026 at 11:13 AM, LPN #16 stated she did not witness the incident between Resident #35 and Resident #44. LPN #16 stated Resident #35 did not report anything to her on the day of the incident. LPN #16 stated that on 11/30/2025, Resident #35 reported their arm was swollen due to Resident #44 shaking their hand too hard, like strong man shakes hands. LPN #16 stated she looked at Resident #35's arm and did not see any discoloration, bruising, or swelling. She stated that she notified the unit manager (UM) and Resident #35's physician, who then ordered an X-ray. During a telephone interview on 01/22/2026 at 3:22 PM, UM #18 stated that she was the weekend supervisor. UM #18 stated LPN #16 reported the incident between Resident #35 and Resident #44 to her on 11/30/2025. UM #18 stated she talked to Resident #35, who reported to her that Resident #44 shook their hand aggressively. UM #18 stated she called whoever was on call that weekend and reported the incident but was unable to recall who she reported it to. UM #18 stated Resident #35's arm appeared slightly swollen, and an X-ray was ordered. During an interview on 01/21/2026 at 2:48 PM, the SSD stated Resident #35 reported to her that they had been sitting in a chair when Resident #44 asked to hold their hand. The SSD stated that Resident #35 declined the request, and Resident #44 grabbed their hand anyway. The SSD stated Resident #35 was upset when they reported the incident. The SSD stated she talked to the ADM, who followed up with Resident #35. During an interview on 01/23/2026 at 9:00 AM, the Director of Nursing (DON) stated she could not recall the specific date of the incident with Resident #35 and Resident #44, but she found out about it on Monday, 12/01/2025. The DON stated she was told that Resident #44 approached Resident #35 and shook Resident #35's hand while telling Resident #35 how much they loved Resident #35. The DON stated that following the incident, Resident #35 was complaining of pain, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	so they ordered an X-ray, and nursing staff assessed Resident #35's hand with no injury noted. The DON stated Resident #35 had slight swelling or edema, but it was not unusual for Resident #35. The DON stated that following the negative X-ray and the nurse not noting any injury, the ADM took over the investigation, and she (the DON) was not very involved. The DON stated that she could appreciate that it should have been reported to that state survey agency. During an interview on 01/23/2026 at 9:41 AM, the ADM stated the incident between Resident #35 and Resident #44 was reported to him on Monday morning, 12/01/2025. The ADM stated Resident #35 reported to him that Resident #44 shook Resident #35's hand hard and said, Oh, I love you so much. The ADM stated he told Resident #35 that it sounded like Resident #44 was just being nice, and Resident #35 stated they did not know why Resident #44 had to touch them. The ADM stated he then talked to Resident #44, who stated they were being polite. The ADM stated he reminded Resident #44 that some residents may not like being touched, and that Resident #44 needed to remember to respect people's personal space. The ADM stated they did not report the incident to the state survey agency because they already determined there was no ill intent or malice within the two-hour time frame. The ADM stated that on 12/02/2025, Resident #35 told him they wanted to report the incident to the police. The ADM stated that the police took a report. The ADM stated that at that time, they decided not to report the incident to the state survey agency because reporting an incident initiated calling the police, but the police had already been to the facility, and the facility staff had already investigated it. The ADM stated that by the time the police came, it was already past the two-hour reporting window. The ADM stated that looking back, when Resident #35 stated they wanted to contact the police, he should have reported the incident to the state survey agency and started a more formal investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on facility policy review, record review, and interview, the facility failed to complete a thorough investigation for an allegation of abuse for 1 (Resident #35) of 2 residents reviewed for abuse. The facility census was 111. Findings included: An undated facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, indicated, Residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. The policy revealed, It is the Facility's policy to investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including Injuries of Unknown Source, in accordance with this policy and to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. The policy revealed, Definitions included, Alleged Violation. A situation or occurrence that is observed or reported by staff, resident, relative visitor or others but has not yet been investigated and, if verified, could be noncompliance with federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. The policy revealed, F. Investigate included, 2. Investigation protocol. The person investigating the incident should generally take the following actions, which included, a. Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. The policy indicated, i. If there are no direct witnesses, then the interviews may be expanded. [For example, consider interviews with all employees on the shift or the unit, as appropriate, as well as other residents on the unit.] The policy further indicated, ii. If the allegation involves abuse/neglect, interview other residents, as appropriate, to determine if they may have been affected by the accused staff member or resident. An admission Record revealed the facility admitted Resident #35 on 06/30/2023. According to the admission Record, the resident had a medical history that included diagnoses of conversion disorder, major depressive disorder, repeated falls, and a history of traumatic brain injury.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/23/2025, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #35 did not exhibit any behaviors during the assessment period and indicated that the resident was independent with activities of daily living (ADLs). Resident #35's Care Plan Report revealed a focus area initiated on 01/24/2024, that indicated the resident had a potential for altered mood pattern and psychosocial wellbeing related to anxiety, decreased independence, and depression.An admission Record revealed the facility admitted Resident #44 on 11/08/2023. According to the admission Record, the resident had a medical history that included diagnoses of obesity, anxiety, and paraplegia. An annual MDS, with an ARD of 10/15/2025, revealed Resident #44 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #44 had rejected care during the assessment review period but did not exhibit any other behaviors during the assessment period. The MDS indicated Resident #44 was dependent on staff for transfers and indicated that the resident used a motorized wheelchair for locomotion. Resident #44's Care Plan Report revealed a focus area revised on 02/20/2025, that indicated the need to monitor Resident #44's behavior due to a potential for altered behavior patterns, disruptive interactions, manipulative behaviors, resisting care, and noncompliance with medications. Interventions directed staff to discourage inappropriate language (initiated 02/20/2025), document each episode (initiated 12/12/2023), establish a daily routine (initiated 02/20/2025), and to explain or reinforce why behaviors were unacceptable (initiated 12/12/2023). Resident #35's Progress Notes revealed a Health Status Note, dated 11/30/2025 at 10:30 AM, that revealed Resident #35 reported that their left wrist was hurting. The note indicated Resident #35 stated their wrist was hurting because of a resident that shook their hand too hard. Per (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the note, Resident #35 reported that the incident occurred on 11/29/2025 at around 1:00 PM. The note indicated that the supervisor and physician were notified and an X-ray was ordered. A handwritten statement dated 12/01/2025 and signed by the Social Services Director (SSD) indicated that Resident #35 stated they were in the lobby when Resident #44 approached Resident #35 and asked to see the resident's hands. The statement indicated that when Resident #35 did not comply with the request, Resident #44 grabbed Resident #35's arms with both hands, causing pain. Resident #35's Radiology Results Report, dated 12/01/2025, indicated that the X-ray of Resident #35's left wrist revealed no fracture or dislocation. A Sheriff's office report dated 12/02/2025 indicated that Resident #35 called in an assault report that occurred on 11/30/2025. The report indicated that the deputy spoke with the Administrator (ADM) who stated that Resident #35 reported to him that Resident #44 approached Resident #35 and asked to make Christmas decorations. Per the report, when Resident #35 declined, Resident #44 took Resident #35 by the arm and wrist and shook it and stated, I just love you. The report indicated no further action was taken due to lack of intent or maliciousness. During an interview on 01/19/2026 at 1:53 PM, Resident #35 stated that Resident #44 grabbed their wrist several months earlier, causing an injury. Resident #35 stated that they called the police and reported the incident. Resident #35 stated that they were told that Resident #44 did not have any malicious intent and was behaving out of love, not aggression, so nothing was going to be done about it. During an interview on 01/21/2026 at 2:31 PM, when resident-to-resident altercation documents were requested from the ADM, the ADM stated the only incident the facility had was when Resident #35 reported that their wrist was hurting from Resident #44 shaking their hand too vigorously, but that it was not an allegation of abuse. During an interview on 01/21/2026 at 9:55 AM, State Tested Nursing Aide (STNA) #15 stated that she was not working the day of the incident between Resident #35 and Resident #44. STNA #15 stated Resident #35 reported to her that Resident #44 had been in their wheelchair and gone by Resident #35 and grabbed Resident #35's arm. During an interview on 01/22/2026 at 11:20 AM, STNA #17 stated she did not witness the incident between Resident #35 and Resident #44 on 11/29/2025. STNA #17 stated that on 11/30/2025, Resident #35 was upset and told the STNA that Resident #44 had grabbed them by the wrist the day before. STNA #17 stated she looked at Resident #35's arm and did not see any signs of injury. STNA #17 stated Resident #35 had already reported the incident to the nurse by the time it was reported to STNA #17. STNA #17 stated she had seen the ADM talking to Resident #35 within the following day or two. During an interview on 01/21/2026 at 10:50 AM, Licensed Practical Nurse (LPN) #6 stated she was not working the day of the incident, but it was reported to her during shift change that Resident #44 shook Resident #35's hand. LPN #6 stated that Resident #35 reported to her that Resident #44 shook their hand hard. During an interview on 01/22/2026 at 11:13 AM, LPN #16 stated she did not witness the incident between Resident #35 and Resident #44. LPN #16 stated Resident #35 did not report anything to her on the day of the incident. LPN #16 stated that on 11/30/2025, Resident #35 reported their arm was swollen due to Resident #44 shaking their hand too hard, like strong man shakes hands. LPN #16 stated she looked at Resident #35's arm and did not see any discoloration, bruising, or swelling. She stated that she notified the unit manager (UM) and Resident #35's physician, who then ordered an X-ray. During a telephone interview on 01/22/2026 at 3:22 PM, UM #18 stated that she was the weekend supervisor. UM #18 stated LPN #16 reported the incident between Resident #35 and Resident #44 to her on 11/30/2025. UM #18 stated she talked to Resident #35, who reported to her that Resident #44 shook their hand aggressively. UM #18 stated she called whoever was on call that weekend and reported the incident but was unable to recall who she reported it to. UM #18 stated Resident #35's arm appeared slightly swollen, and an X-ray was ordered. During an interview on 01/21/2026 at 2:48 PM, the SSD stated Resident #35 reported to her that they had been sitting in a chair when Resident #44 asked to hold their hand. The SSD stated that Resident #35 declined the request, and Resident #44 grabbed their hand anyway. The SSD stated Resident #35 was upset when they reported the incident. The SSD stated she did not get any other statements from anyone regarding the incident. The SSD stated (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookwood Care Center	12100 Reed Hartman Highway Cincinnati, OH 45241

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she talked to the ADM, who followed up with Resident #35. During an interview on 01/23/2026 at 9:00 AM, the Director of Nursing (DON) stated she could not recall the specific date of the incident with Resident #35 and Resident #44, but she found out about it on Monday morning, 12/31/2025. The DON stated she was told that Resident #44 approached Resident #35 and shook Resident #35's hand while telling Resident #35 how much they loved Resident #35. The DON stated that following the incident, Resident #35 was complaining of pain, so they ordered an X-ray, and nursing staff assessed Resident #35's hand with no injury noted. The DON stated Resident #35 had slight swelling or edema, but it was not unusual for Resident #35. The DON stated that following the negative X-ray and the nurse not noting any injury, the ADM took over the investigation, and she (the DON) was not very involved. The DON stated she was not aware of any further investigation into the incident. During an interview on 01/23/2026 at 9:41 AM, the ADM stated the incident between Resident #35 and Resident #44 was reported to him on Monday morning, 12/01/2025. The ADM stated Resident #35 reported to him that Resident #44 shook Resident #35's hand hard and said, Oh, I love you so much. The ADM stated that he told Resident #35 that it sounded like Resident #44 was just being nice, and Resident #35 stated they did not know why Resident #44 had to touch them. The ADM stated he then talked to Resident #44, who stated they were being polite. The ADM stated he reminded Resident #44 that some residents may not like being touched, and that Resident #44 needed to remember to respect people's personal space. The ADM stated that on 12/02/2025, Resident #35 told him they wanted to report the incident to the police. The ADM stated that the police took a report. The ADM stated that as part of an investigation, they normally interviewed other residents, but no other residents had been interviewed in this case. The ADM stated that looking back, when Resident #35 stated they wanted to contact the police, he should have reported the incident to the state survey agency and started a more formal investigation.

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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 interview, record review, and facility policy review, the facility failed to ensure person-centered care plans were developed and implemented for 2 (Resident #10 and Resident #110) of 3 residents reviewed with a diagnosis of Post Traumatic Stress Disorder (PTSD). The facility census was 111. Findings included:A facility policy titled, Trauma Informed Care, dated 05/30/2025, revealed, It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. The policy also indicated, 4. The facility will collaborate with the resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions.A facility policy titled, Care Planning, dated 08/2021, revealed, Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident.1. An admission Record revealed the facility admitted Resident #10 on 09/25/2025. According to the admission Record, the resident had a medical history that included a diagnosis of post-traumatic stress disorder (PTSD).A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/01/2026, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had diagnoses that included PTSD.Resident #10's Care Plan Report, initiated 09/29/2025, did not address PTSD, include interventions for PTSD, or identify PTSD triggers.A BH [Behavioral Health] Progress Note, dated 12/05/2025, revealed Resident #10 had past psychiatric diagnoses that included PTSD.During an interview on 01/21/2026 at 12:06 PM, State Tested Nurse Aide (STNA) #1 stated she was aware of Resident #10, but she was unaware Resident #10 had PTSD and did not know about any triggers the resident had. During an interview on 01/21/2026 at 12:13 PM, Licensed Practical Nurse (LPN) #2 stated she was aware that Resident #10 had PTSD. LPN #2 stated she thought Resident #10's PTSD was related to a fall at a previous facility, where an aide turned the resident and the resident flipped out of bed and fractured both femurs. LPN #2 stated Resident #10's care plan did not contain PTSD triggers and interventions.During an interview on 01/21/2026 at 12:26 PM, STNA #3 stated she was not aware the resident had PTSD or if they had any triggers.During an interview on 01/21/2026 at 12:44 PM, Resident #10 stated they got pushed out of bed at another facility and broke both my legs during care. Resident #10 stated that since then they got very scared when they were changed and rolled. Resident #10 stated that was why they wanted their bed against a wall.On 01/22/2025 at 9:49 AM a concurrent interview was conducted with Minimum Data Set Coordinator (MDSC) #4 and the Regional Minimum Data Set Coordinator (RMDSC). MDSC #4 stated they did not put PTSD interventions and triggers on the care plan. The RMDSC stated that not every resident with a PTSD diagnosis had triggers. MDSC #4 and the RMDSC were unable to define how staff caring for Residents #10 would know the resident's PTSD triggers.During an interview on 01/22/2026 at 11:14 AM, the Director of Nursing stated if a resident had PTSD, she expected they would have an individualized care plan related to PTSD. During an interview on 01/23/2027 at 10:05 AM, the Administrator stated his expectation was that PTSD care planning met the regulation requirement. 2. An admission Record revealed the facility admitted Resident #110 on 08/30/2025. According to the admission Record, the resident had a medical history that included a diagnosis of PTSD.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/05/2025, revealed Resident #110 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had diagnoses that included PTSD.Resident #110's Care Plan Report, initiated 09/02/2025, did not address PTSD, include interventions for PTSD, or identify (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PTSD triggers.A BH [Behavioral Health] Progress Note, dated 01/12/2026, revealed the resident had past psychiatric diagnoses that included chronic PTSD.During an interview on 01/21/2026 at 12:06 PM, State Tested Nurse Aide (STNA) #1 stated she was aware of Resident #110, but she was unaware the resident had PTSD and did not know about any triggers the resident had.During an interview on 01/21/2026 at 12:19 PM, Licensed Practical Nurse (LPN) #6 stated she was unaware Resident #110 had PTSD and did not know if they had any triggers. LPN #6 stated if there were triggers related to PTSD, she would look on the care plan to see what they were.During an interview on 01/21/2026 at 12:29 PM, STNA #3 stated she was not aware Resident #110 had PTSD or if they had any triggers.On 01/22/2025 at 9:49 AM a concurrent interview was conducted with Minimum Data Set Coordinator (MDSC) #4 and the Regional Minimum Data Set Coordinator (RMDSC). MDSC #4 stated they did not put PTSD interventions and triggers on the care plan. The RMDSC stated that not every resident with a PTSD diagnosis had triggers. MDSC #4 and the RMDSC were unable to define how staff caring for Resident #110 would know the resident's PTSD triggers.During an interview on 01/22/2026 at 11:14 AM, the Director of Nursing stated if a resident had PTSD, she expected they would have an individualized care plan related to PTSD. During an interview on 01/23/2027 at 10:05 AM, the Administrator stated his expectation was that PTSD care planning met the regulation requirement.

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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. Based on facility policy review, record review, observation, and interview, the facility failed to ensure residents' environment remained free of accident hazards when staff failed to ensure unprescribed, over the counter medications were not in residents' rooms. The deficiency affected 1 (Resident #104) of 4 residents reviewed for medication administration. The facility census was 111. Findings included:A facility policy titled, Storage of Medications, last reviewed 11/2025, indicated, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.An admission Record revealed the facility admitted Resident #104 on 03/14/2023. According to the admission Record, the resident had a medical history that included diagnoses of emphysema, osteoporosis, muscle weakness, generalized anxiety disorder, and cognitive communication deficit. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/17/2025, revealed Resident #104 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #104 required set-up assistance with eating and oral hygiene. Resident #104's Care Plan Report revealed a focus area revised on 03/22/2024, that indicated the resident had the potential for cognitive and communication deficits related to forgetfulness and difficulty making decisions and had a goal of maintaining the resident's safety. Interventions initiated 09/20/2023 directed staff to assist Resident #104 with decision-making tasks as needed, and to encourage the resident to participate with activities of daily living. An observation on 01/19/2026 at 1:47 PM revealed Resident #104 lying in bed. A tube of hydrocortisone cream was on the resident's bedside table. A bottle of antacids was on the resident's dresser. An observation on 01/21/2026 at 9:20 AM revealed Resident #104 in their wheelchair in their room. A tube of hydrocortisone cream was on was on the resident's bedside table. A bottle of antacids was on the resident's dresser. Resident #104's Order Summary Report, with active orders as of 01/21/2026, revealed no active orders for antacids or hydrocortisone cream. The Order Summary Report also revealed no active orders for the resident to self-administer medication.During an interview on 01/21/2026 at 10:18 AM, State Tested Nurse Aide (STNA) #14 stated residents were not allowed to keep medications in their rooms. STNA #14 stated that if she saw medications in a resident's room, she would report them to the nurse. During an interview on 01/21/2026 at 10:50 AM, Licensed Practical Nurse (LPN) #6 stated residents were not allowed to keep medications in their rooms unless they had been approved to self-administer medications, and it had been approved by the physician. LPN #6 stated residents should not keep medications in their rooms because some residents had cognitive issues, and staff needed to ensure the resident was taking the medications correctly. LPN #6 stated residents should have orders for all medications, including over-the-counter medications. When LPN #6 was shown the hydrocortisone cream and the antacids in Resident #104's room, LPN #6 stated she had not seen the medications in Resident #104's room, and the medications should not be in the room. LPN #6 stated Resident #104 was extremely confused. LPN #6 then asked Resident #104 where the antacids came from, and Resident #104 responded that they did not know where the medication came from; they were just there. During an interview on 01/23/2026 at 9:00 AM, the Director of Nursing (DON) stated medications should not be stored in a resident's room unless there was an assessment completed and the resident was safe to keep their own medications. The DON stated residents' family members sometimes brought medications into the facility, but it was the responsibility of the facility's staff to remove the medications from resident rooms and to educate families not to bring in outside medications. During an interview on 01/23/2026 at 9:41 AM, the Administrator (ADM) stated medications should not be stored in residents' rooms. The ADM stated residents could not keep medications in their rooms, especially if they were cognitively impaired.

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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. Based on observation, interview, and facility policy review, the facility failed to ensure staff adhered to infection prevention and control practices by not wearing appropriate personal protective equipment (PPE) during high-contact resident care for a resident on Enhanced Barrier Precautions (EBP) for 1 (Resident #13) of 10 residents reviewed for EBP. The facility census was 111. Findings included:A facility policy titled Enhanced Barrier Precautions Policy and Procedure, dated 11/2019, revealed, Procedure: 1. Implement enhanced barrier precautions in the following situations: a) Residents with infection or colonization with a novel or targeted MDRO [multi-drug resistant organism] when Contact Precautions do not apply. b) All residents with wounds, indwelling medical devices (i.e., central line, urinary catheter, feeding tube, trach [tracheostomy] regardless of MDRO colonization status when residing in an at-risk area (i.e., a resident with a novel or targeted MDRO is residing on the unit. The policy also indicated, 3. Gown and gloves will be placed immediately outside of the resident room. 4. Gown and gloves use will be used, in addition to standard precautions, in the following activities: a) Dressing b) Bathing/showering c) Transferring d) Providing hygiene e) Changing linens f) Changing briefs or assisting with toileting g) Device care or use (central line, urinary catheter, feeding tube, tracheostomy) h) Wound care/any skin opening requiring a dressing.An admission Record revealed the facility admitted Resident #13 on 01/31/2025. According to the admission Record, the resident had a medical history that included diagnoses of gastrostomy (a surgical opening through the abdominal wall into the stomach) status and dependence on renal dialysis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/07/2025, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #13 had an indwelling urinary catheter, an ostomy (a surgical opening on the abdomen to allow waste to exit the body) was present, and the resident had one unstageable pressure ulcer. Resident #13's Care Plan included a focus area, revised on 05/29/2025, that indicated the resident required EBP related to a feeding tube, urostomy (a surgical opening to allow urine to leave the body), colostomy (an opening in the intestine to allow stool to pass from the body), and a wound. Interventions directed staff: to clean hands prior to entering and leaving the resident's room (revised 07/28/2025); to not wear the same gloves and gown for the care of more than one resident (revised 07/28/2025); to ensure signage remained on the door at all times (revised 07/28/2025); that gloves and gown were to be worn when providing high-contact resident care activities (dressing, bathing, transferring, changing linens, providing hygiene, toileting, giving care to central lines, urinary catheter, feeding tubes, tracheostomy, respiratory device care, wound care) (revised 07/28/2025); and staff and providers were to properly don and doff PPE (revised 07/28/2025). An observation on 01/19/2026 at 9:53 AM revealed an EBP sign on Resident #13's door. The observation revealed the Physical Therapy Assistant (PTA) was providing a wound treatment to Resident #13's wound on the back of the right thigh, and the PTA had not donned a gown.An observation on 01/22/2026 at 10:25 AM revealed State Tested Nurse Aide (STNA) #20 and STNA #24 in Resident #13's room. The observation revealed STNA #24 was standing behind Resident #13, STNA #20 was standing in front of the resident, and the resident was sitting up in bed, preparing to transfer. During an interview on 01/19/2025 at 9:53 AM, the PTA revealed she unaware that Resident #13 required PPE. The PTA stated she did not see the signage on the door, and, if she had known, she would have donned a gown as well as gloves to provide the wound treatment. During an interview on 01/22/2026 at 2:19 PM, STNA #24 revealed she was in the room assisting Resident #13 to transfer, and she did not have on a gown. During an interview on 01/23/2026 at 9:45 AM, the Director of Nursing (DON) revealed she expected staff to ensure signage was on the resident's door when EBP was required, and she expected staff to follow the signage and orders and wear the appropriate PPE. During an interview on 01/23/2026 at 10:03 AM, the Administrator revealed that he was not clinical, but he expected the facility's policy and procedures to be followed.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the results of previous most recent surveys were readily accessible for resident and visitor review on 5 (01/19/2026, 01/20/2026, 01/21/2026, 01/22/2026, and 01/23/2026) of 5 survey days. This had the potential to affect all residents. The facility census was 111.Findings included:On 01/19/2026 at 8:36 AM, upon entrance to the facility, an observation of a binder located in the facility's lobby titled Resident Information Book revealed federal and state surveys for years 2020 through 2021, and there were no survey results posted after a complaint survey dated 03/04/2021.On 01/20/2026 at 3:55 PM, an observation of a binder located in the facility's lobby titled Resident Information Book revealed state surveys for the years 2020 through 2021, and there were no survey results posted after a complaint survey dated 03/04/2021.On 01/21/2026 at 5:19 AM, an observation of a binder located in the facility's lobby titled Resident Information Book revealed state surveys for the years 2020 through 2021, and there were no survey results posted after a complaint survey dated 03/04/2021.On 01/22/2026 at 12:09 PM, an observation of a binder located in the facility's lobby titled Resident Information Book revealed state surveys for the years 2020 through 2021, and there were no survey results posted after a complaint survey dated 03/04/2021.On 01/23/2026 at 8:50 AM, an observation of a binder located in the facility's lobby titled Resident Information Book revealed state surveys for the years 2020 through 2021, and there were no survey results posted after a complaint survey dated 03/04/2021. During an interview on 01/23/2026 at 8:51 AM, Receptionist (REC) #8, stated there were no additional locations in the lobby where survey reports were available to the residents and the public. REC #8 reviewed the binder and confirmed the most recent survey report in the binder was from a survey dated 03/04/2021.During an interview on 01/23/2026 at 9:10 AM, the Administrator (ADM) stated he was not sure if survey inspection reports were located anywhere else at the facility. The ADM confirmed the last report in the binder was from 2021.An observation on the facility's third-floor hall/[NAME] Hall, on 01/23/2026 at 9:14 AM, revealed a notice posted on a bulletin board in the hallway that indicated survey information was located on the kitchen counter of [NAME] Hall. An observation of the kitchen counter in The Club room of [NAME] Hall did not reveal any survey information. During an interview on 01/23/2026 at 9:20 AM, Wound Care Clinician (WCC) #7 stated there was no survey information located on the kitchen counter of [NAME] Hall, and there were no other kitchen counters on [NAME] Hall, other than the one in The Club room.An observation of the facility's second floor hall/Sycamore Hall on 01/23/2026 at 9:38 AM did not reveal any postings related to the availability of survey inspection reports.An interview was conducted with the Director of Nursing (DON) on 01/23/2026 at 9:50 AM. The DON stated it was her expectation that all survey inspection information was easily available to the residents and the public. During an interview on 01/23/2026 at 10:05 AM, the Administrator (ADM) confirmed the most recent survey inspection reports were not in the binder nor easily accessible to residents and the public. The ADM stated the facility did not have a policy related to posting survey information, saying the facility goes by the regulation. The ADM stated it was his expectation survey results were posted and available for resident and visitor review.