STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365733	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Margaret Hall	1960 Madison Road Cincinnati, OH 45206

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, observations, and staff and resident interview, the facility failed to ensure a resident who was dependent on staff with transferring out of bed received timely assistance with activities of daily living (ADL). This affected one (Resident #3) of one resident reviewed for ADLs. The facility census was 87. Findings include: Review of the medical record for Resident #3 revealed an admitted [DATE]. Her medical diagnoses included coronary artery disease, heart failure, and cerebrovascular attack (CVA). Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was severely cognitively impaired. Her functional status was substantial/maximal from staff for bed mobility and dependent on staff for transfers. Observations and interviews on 09/29/24 at 8:51 A.M. revealed State tested Nursing Aide (STNA) #227 was in the room and Resident #3 had her food in front of her. STNA #227 asked the resident if she would like to get out of bed after breakfast and the resident said yes she would. Subsequent observations on 09/29/24 at 10:25 A.M. revealed Resident #3 was in bed and said she didn't know where the STNA was. At 11:40 A.M., Resident #3 was in bed and said the STNA had not come back to get her dressed for the day. At 12:52 P.M., Resident #3 was in bed and stated the STNA had not come into the room to get her dressed. Interview with STNA #227 on 09/29/24 at 12:56 P.M. confirmed she didn't get Resident #3 out of bed after she requested to get up out of bed after breakfast. STNA #227 did not provide an explanation why she didn't get Resident #3 out of bed after breakfast. This deficiency represents non-compliance in Complaint Number OH00157615.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, observations, and family and staff interviews, the facility failed to ensure the residents who were at risk for developing pressure ulcer were turned and repositioned every two to three hours per their care plan interventions and failed to complete treatments to the right heel ordered by the physician at the hospital. This affected three (#10, #18, and #72) three residents reviewed for change of positioning. The facility census was 87. Findings include: 1. Medical record review for Resident #18 revealed an admitted [DATE]. Medical diagnoses included fracture of the right lower extremity for after care healing. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively intact. Review of the hospital orders for the right heel wound for Resident #18 dated 09/04/24 revealed there was mild drainage to the right heel and sutures were removed. The resident was advised to relieve pressure from the heel wound as she could tolerate. Resident #18 was advised to keep the dressing on the heel wound for three days and then remove it and wash daily with soap and water. Resident #18 was to follow up with orthopedic surgery on 09/26/24 and continue wound care for the right heel instructions until the time of the appointment on 09/26/24. Review of the physician orders from 09/04/24 to 09/15/24 revealed there were no physician orders to provide treatment to the right heel. Review of the dressing changes for the right heel for Resident #18 revealed there was no documentation the wound treatment to the right heel wound was completed after admission through 09/15/24. Interview with the Director of Nursing (DON) on 09/30/24 at 8:30 A.M. confirmed there wasn't any dressing changes or physician orders to cleanse the right heel wound for Resident #18 three days after admission through 09/15/24. 2. Medical record review for Resident #72 revealed an admitted [DATE]. Medical diagnoses included diabetes mellitus, heart failure, renal insufficiency, and respiratory failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was severely cognitively impaired. Resident #72 was dependent on staff for bed mobility and transfers. Review of the care plan dated 07/04/24 for Resident #72 revealed she was at risk for developing pressure ulcers and skin injuries. Interventions included to turn and reposition the resident every two hours. Observations on 09/25/24 at 9:06 A.M. revealed Resident #72 was in bed and leaning to her right side of the bed. Subsequent observations on 09/29/24 at 9:03 A.M., 10:29 A.M., 11:46 A.M., and 1:02 P.M. revealed Resident #72 was lying in bed on her right side. There were no pillows under the resident. There was no indication Resident #72 was turned and repositioned on 09/29/24. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Licensed Practical Nurse (LPN) #250 on 09/29/24 at 1:10 P.M. stated she only turned the residents if staff asked her to assist. She denied the State tested Nursing Aide (STNA) asked her for help with turning Resident #72 on 09/29/24. Interview with STNA #170 on 09/29/24 at 1:12 P.M. confirmed she did not turn and reposition Resident #72 that day (09/29/24). 3. Medical record review for Resident #10 revealed an admitted [DATE]. Medical diagnoses included dementia and renal insufficiency. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was rarely or never understood. Her functional status was substantial/maximal from staff for bed mobility and was dependent on staff for transfers. Review of the care plan dated 09/11/24 revealed Resident #10 was at risk for developing a pressure ulcer. Interventions included to turn and reposition every two-to-three hours. Observations on 09/29/24 at 9:02 A.M., 10:28 A.M., 11:45 A.M. and 1:01 P.M. revealed Resident #10 was lying in bed in the same position, with a pillow under her left buttock leaning to the right of the bed. There was no indication Resident #10 was turned and repositioned on 09/29/24. Interview with Licensed Practical Nurse (LPN) #250 on 09/29/24 at 1:10 P.M. revealed she only turned the residents if staff asked her to assist. She denied the state tested nursing aide (STNA) asked her for help with turning Resident #10 on 09/29/24. Interview with STNA #170 on 09/29/24 at 1:12 P.M. confirmed she hadn't turned Resident #10 that day (09/29/24). Interview with Resident #10's family on 09/30/24 at 9:04 A.M. stated they visited everyday and the staff do not turn Resident #10 on a regular basis. This deficiency represents non-compliance investigated under Complaint Number OH00157615.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, staff interview and policy review, the facility failed to ensure the resident's bladder scans were completed for a trial after the indwelling catheter was removed per hospital discharge orders. This affected one (#18) of one resident reviewed for bladder scanning. The facility census was 87. Findings include: Medical record review for Resident #18 revealed an admitted [DATE]. Medical diagnoses included fracture of the right lower extremity for after care healing. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively intact. Her functional status was substantial/maximal assistance from staff for toileting and bed mobility, and supervision from staff for transfers. Review of the hospital orders dated 09/04/24 revealed Resident #18 had a indwelling catheter while at the hospital and it was removed and the plan was for Resident #18 to go to the nursing home for a trial. The orders were to obtain bladder scans every six hours and straight catheterize if the resident was retaining more than 300 milliliters (ml). If bladder scans for more than 24 hours remain more than 300 ml and the resident was maintaining adequate urine output, then discontinue further bladder scans. Resident #18's medical record did not have documentation of bladder scans on 09/04/24 and 09/05/24. There were only two bladder scans completed on 09/06/24, which were at 10:47 P.M. when the nurse completed a bladder scan and the first reading was 543 ml and the second reading was 511 ml. The charge nurse tried multiple times to straight catheterize Resident #18 but was unsuccessful. There was no documentation to show the physician was called for the delay of the bladder scanning order for two days or that Resident #18 could not be catheterized on 09/06/24. Interview with the Director of Nursing (DON) on 09/30/24 at 8:29 A.M. confirmed the physician wasn't called to report the bladder scanning wasn't started upon admission or the physician was notified concerning the nurse not being able to straight catheterize Resident #18 on 09/06/24. Review of the policy titled Notification of Change, dated 08/01/17, revealed the facility shall promptly notify the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative(s) when there are changes in the resident's condition or status, in order to obtain orders for appropriate treatment and monitoring and promote the resident's right to make choices about treatment and care preferences. This deficiency represents non-compliance investigated under Complaint Number OH00157917.