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	01/27/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, staff interview, and observation, the facility failed to ensure the phones were answered during the nighttime hours. This affected one (Resident #45) of three residents reviewed for communication with the staff via telephone. This had the potential to affect all of the residents. The facility census was 73 residents. Findings include: Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses including arthritis, malnutrition, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment for Resident #45 dated 12/32/24 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the progress note for Resident #45 dated 12/31/25 timed at 11:13 A.M. per Licensed Practical Nurse (LPN) #102 revealed at around 5:45 A.M. the resident's family entered the facility with emergency medical technicians (EMT's) because they weren't able to get in touch with the facility via telephone. Resident #45 had called the family because he had fallen in his room. Interview on 01/23/25 at 12:00 P.M. with the Director of Nursing (DON) confirmed the night shift nursing supervisor didn't report to work on 12/30/24. The DON confirmed the receptionist had left the phone on the desk for the night shift nurse supervisor to pick up once she arrived. Further interview with the DON confirmed when Resident #45's family called the facility on 12/30/24, no one answered the phone. The DON confirmed LPN #102 was educated on the importance on making sure to retrieve the phone from the reception desk and was terminated for safety violations. Observations on 01/25/25 at 7:30 P.M. and 10:00 P.M., on 01/26/25 at 1:51 A.M. and 6:37 P.M., and on 01/27/25 at 5:38 A.M of Surveyor phone calls to the facility revealed the phone rang one time, and then an answering machine picked up the call with a recorded greeting announcing the caller had reached the supervisor's phone followed by a prompt to leave a message. (continued on next page)

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/27/25 at 7:53 A.M. with Registered Nurse (RN) #105 confirmed she was the supervisor in charge for 01/25/25 and 01/26/25 and she kept the facility phone on her person and answered it when calls came in over the weekend. RN #105 said she believed the Surveyor calls went straight to voicemail because the calls had not been properly forwarded by the front desk staff before they left for the evening. RN #105 confirmed resident representatives and other parties should be able to reach a staff person directly when calling into the facility, especially in case of an emergency. This deficiency represents noncompliance investigated under Complaint Number OH 00161275.

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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 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, observation, and staff interview, the facility failed to ensure incontinence care was provided in a timely manner. This affected one (Resident #36) of three residents reviewed for incontinence care. The facility census was 73 residents. Findings include: Review of the medical record review for Resident #36 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia and non-Alzheimer's dementia. Review of the care plan for Resident #36 dated 08/24/24 revealed the resident was at risk for urinary incontinence with the potential for impaired skin integrity. Interventions included the following: keep call light within reach and remind the resident to use it, check and change frequently and provide good peri-care, observe for signs and symptoms of restlessness which might indicate the need to void, offer assistance to the bathroom as needed. Review of the Minimum Data Set (MDS) assessment for Resident #36 dated 01/03/25 revealed the resident was cognitively intact, required substantial staff assistance with toileting, bed mobility, and transfers, and was frequently incontinent of bladder and occasionally incontinent of bowel. Observation on 01/22/25 at 10:52 A.M. of Resident #36 revealed the resident was sitting in her room in her recliner. There was an odor of feces in the air and there was no trash in the garbage can and the toilet was clean. Observation on 01/22/25 at 11:09 A.M. revealed Certified Nursing Assistant (CNA) #107 entered Resident #36's room and said she had changed the resident her a little bit ago. Observation on 01/22/25 at 11:44 A.M. revealed CNA #107 walked down the hall and looked into Resident #36's room and then continued down the hall. Observation on 01/22/25 at 12:05 P.M. revealed CNA #107 returned from a break and went to Resident #36's door, but didn't go into the room. Observation on 01/22/25 at 12:07 P.M. revealed CNA #107 and Unit Manager (UM) #110 transferred the resident into a wheelchair using a Hoyer lift and the fecal smell persisted. Observation on 01/22/25 at 1:35 P.M. revealed CNA #107 changed Resident #36's incontinence brief. The resident had been incontinent of stool and urine. Interview on 01/22/25 at 1:37 P.M. with CNA #107 confirmed she changed Resident #36's incontinence brief at 8:30 A.M. and did not offer incontinence care again until 1:35 P.M. CNA #107 she was supposed to change Resident #36's incontinence brief every two hours, but she had not done so. This deficiency represents noncompliance investigated under Complaint Number OH 00161798.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure staff provided the appropriate level of supervision during resident transfers using the sit to stand lift. This affected one (Resident #36) of three residents reviewed for falls. The facility census was 73 residents. Findings include: Review of the medical record for Resident #36 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia and non-Alzheimer's dementia. Review of care plan for Resident #36 dated 08/14/24 revealed the resident was at risk for falls related to impaired mobility. The care plan had not been updated to reflect the use of a sit to stand lift for transferring the resident. Review of the Minimum Data Set (MDS) assessment for Resident #36 dated 01/03/25 revealed the resident was cognitively intact and required substantial/maximal assistance of staff for for toileting, bed mobility, and transfers. Review of the sit to stand assessment for Resident #36 dated 01/11/25 revealed therapy recommended the resident be transferred using the sit to stand lift. Review of the fall risk assessment for Resident #36 dated 01/13/25 revealed the resident was at risk for falls. Review of the progress note for Resident #36 dated 01/16/25 revealed Certified Nursing Assistant (CNA) #112 was transferring Resident #36 from the chair to the bed using a sit to stand lift, and the resident slid to the floor during the transfer. Staff assessed Resident #36 for injuries and finding no injuries, three staff members using a gait belt assisted the resident to get back to bed. Review of the Interdisciplinary Team (IDT) note for Resident #36 dated 01/17/25 revealed CNA #112 was to be educated on proper lift technique. Interview on 01/27/25 at 10:59 A.M. with the Director of Nursing (DON) confirmed on 01/16/25 CNA #112 had transferred Resident #36 using the sit to stand lift without the appropriate level of supervision resulting in a fall without injuries. The DON confirmed there should be two staff members when transferring residents using the sit to stand lift. The DON further confirmed CNA #112 was terminated for violating the facility policy for mechanical lift transfers. Review of the facility policy entitled Using a Mechanical Lifting Machine dated 2001 revealed at least two nursing assistants were needed to safely move a resident with a mechanical lift, and this included the use of a sit to stand lift. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Number OH 00161798.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, observation, staff interview, resident interview, and review of the facility policy, the facility failed to ensure the temperature in resident rooms was satisfactory. This affected one (Resident #43) of three residents reviewed for the physical environment. The facility census was 73 residents. Findings include: Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including [NAME] Syndrome, malnutrition, depression, respiratory disorder, and biliary cirrhosis. Review of the Minimum Data Set (MDS) assessment for Resident #43 dated 01/11/25 revealed the resident was cognitively intact and required assistance with activities of daily living (ADLs.) Observation on 01/22/25 at 1:12 P.M. of Resident #43 revealed the resident was sitting in her room wearing an oversized house coat and gloves. The heater was blowing out cold air. Interview on 01/22/25 at 1:14 P.M. with Resident #43 confirmed she was cold in her room and the heater was blowing out cold air. She stated she had been complaining about the coldness in her room since October 2024 with no resolution. Resident #43 confirmed she had a space heater her brother bought her, but staff had taken it out of her room earlier in the morning of 01/22/25. Resident #43 confirmed Maintenance Man (MM) #100 had come and adjusted the heater a couple of times, but it wasn't fixed, and her room was freezing. Observation on 01/22/25 at 1:30 P.M of room temperatures of Resident #43's room per MM #100 revealed the air temperature in the room was 68 degrees Fahrenheit (F.) Interview on 01/22/25 at 1:31 P.M. of MM #100 confirmed he knew about the resident's room being cold and had checked it a couple of times and adjusted the heat. MM #100 confirmed the air temperature in Resident #36's room was 68 degrees F, and the room was too cold. Review of the facility policy titled Safe and Homelike Environment updated 01/22/25 revealed the facility would maintain comfortable and safe temperature levels. The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees F.