

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365772	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Eastgate Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4400 Glen Este Withamsville Road Cincinnati, OH 45245	
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, staff interview, facility document review, and policy review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This had the potential to affect all the residents who received nourishment from the kitchen. Findings include: Observation on 08/18/25 at 9:40 A.M. of the walk-in refrigerator revealed it included the following: a large container of pancake batter with an open date of 08/12/25 and a discard date of 08/17/25, a large, opened container of sour cream without an open date, a large, opened container of canola oil without an open date. Interview on 08/18/25 at 9:44 A.M. with the Corporate Chef (CC) confirmed items in the refrigerator should have an open date and a discard date and items should be discarded by the discard date. The CC confirmed the sour cream and canola oil lacked open dates, and the pancake batter should have been discarded by the discard date on the label. 2. Observation on 08/18/25 at 9:43 A.M. of the dry storage revealed there were 21 boxes of salt which appeared to be damaged by liquid, and the contents inside were hardened. Interview on 08/18/25 at 9:49 A.M. with the Executive Chef (EC) confirmed damaged foods should be thrown away. The EC stated the boxes of salt had liquid damage, the contents were hardened, and the boxes of salt should have been discarded. Review of the facility policy titled Safe Food Handling and Storage dated June 2015 revealed the proper storage and handling of all foods, whether potentially hazardous or not, was essential in preventing chemical, physical or biological contamination.		

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 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 medical record review, staff interview, facility document review, and review of the facility policy, the facility failed to ensure allegations of abuse were reported to the state survey agency (SSA). This affected two (Residents #156 and Resident #120) of three residents reviewed for abuse. Findings include: 1. Review of the medical record for Resident #52 revealed an admission date of 12/26/2023 with diagnoses of schizophrenia and bipolar disorder. Review of the MDS for Resident #52 dated 05/21/25 revealed the resident had intact cognition. Review of the care plan for Resident #52 dated 04/16/24 revealed the resident had a history of behaviors which included wandering and making inappropriate comments to staff. Interventions included the following: direct staff to assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, offer tasks that divert the resident's attention. Review of the medical record for Resident #156 revealed an admission date of 09/20/23 with a diagnosis of dementia with behavioral disturbances and a discharge date of 05/12/25. Review of the Minimum Data Set (MDS) assessment for Resident #156 dated 05/06/25 revealed the resident had severe cognitive impairment. Review of a progress note for Resident #156 dated 05/01/25 at 7:41 P.M. per Registered Nurse (RN) #14 revealed the the resident's power of attorney (POA) expressed concern about an interaction they reportedly saw between Resident #156 and another resident and asked if the incident was documented. RN #14 told the POA that they could not release any information until they spoke to their supervisor to ensure there were no privacy violations. Review of the progress note for Resident #156 dated 05/02/25 at 12:05 PM revealed the facility held a care conference with a family member to discuss the resident's escalated verbal and physical behaviors. The note did not address any resident-to-resident incidents. Review of the progress note for Resident #156 dated 05/12/25 at 1:21 P.M. revealed the facility held a care conference with the resident's representative where they discussed the resident's care. The note did not address any resident-to-resident incidents. Interview on 08/21/25 at 7:35 P.M. with Resident #156's representative, Resident Representative (RR) #23 confirmed on 04/26/25 at approximately 7:00 P.M. Resident #156 was watching television when Resident #52 approached Resident #156's room door with their pants down. RR #23 stated Resident #52's belt was unbuckled, their pants were unbuttoned, the zipper was down, and the resident's pants were down to the resident's knees. RR #23 stated they intervened before Resident #52 pulled down their (Resident #52's) brief. RR #23 stated they told Resident #52 to leave Resident #156's room, and once Resident #52 left, RR #23 asked Resident #156 what happened. RR #23 stated that Resident #156 told them that Resident #52 was going to show the resident their genitalia. RR #23 stated they went to the nurses' station at approximately 7:00 P.M. and notified the outgoing and incoming nurses of the interaction between Resident #156 and Resident #52. RR #23 stated staff told them they would keep an eye on the residents and would ensure they were separated. RR #23 stated they contacted the facility on 05/01/25 and spoke with an RN to ensure the facility administration was notified of the interaction. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RR #23 stated that on 05/02/25 they called and notified a social worker who stated they would notify the Administrator. RR #23 stated on 05/02/25, they received a return call from the Administrator, the Director of Nursing (DON), and the Social Services Designee (SSD). RR #23 stated that during the phone call, they informed the facility staff of the incident and requested an in-person meeting. RR #23 stated that on 05/12/25 an in-person meeting was held with RR #23, the Administrator, the DON, the SSD, and the Assistant Director of Nursing (ADON), and RR #23 discussed the incident during the meeting. Interview on 08/22/25 at 10:53 A.M. with RN #14 confirmed RR #23 had mentioned an incident about Resident #52 exposing himself but stated he did not remember whether RR #23 had reported the incident to him. RN #14 further confirmed if RR #23 had reported something to him, he would have notified the Administrator immediately. Interview on 08/22/25 at 10:20 A.M. with RN #8, who was the former ADON, stated she was notified of the incident between Resident #52 and Resident #156 on 05/01/25. RN #8 stated RR #23 had wanted to speak with management regarding an incident between Resident #156 and Resident #52. RN #8 stated she spoke with RR #23 who stated Resident #156 was sitting on their bed watching television when RR #23 witnessed Resident #52 approaching the room with their pants down to their hips. RN #8 that RR #23 reportedly told Resident #52 that it was not their room, and the resident turned and left. Interview on 08/21/25 at 3:49 P.M. with the SSD confirmed during a meeting with RR #23, the Administrator, and the DON on 05/12/25, RR #23 alleged Resident #52 exposed himself to Resident #156. The SSD revealed the meeting was documented in a progress note, but the allegation of possible resident-to resident abuse was not documented. Interview on 08/21/25 at 4:00 P.M. with the DON confirmed she attended a meeting where RR #23 alleged Resident #52 attempted to expose their genitals to Resident #156. Interview on 08/21/25 at 5:14 P.M. with the Administrator confirmed he was the Abuse Coordinator for the facility and recalled a meeting was held regarding Resident #156's behaviors. The Administrator confirmed during the meeting, RR #23 reported that Resident #52 attempted to expose himself to Resident #156 on 04/26/25. The Administrator confirmed the facility did not report the incident to the SSA. 2. Review of the medical record for Resident #120 revealed and admission date of 11/07/24 with diagnoses including chronic obstructive pulmonary disease, Alzheimer's disease, and major depressive disorder. Review of the MDS for Resident #120 date 06/04/25 revealed the resident had severe cognitive impairment and required supervision with activities of daily living (ADLs.) Review of the medical record for Resident #117 revealed and admission date of 03/22/25 with diagnoses including unspecified dementia without behavioral disturbance, adjustment disorder with anxiety, and hypertension. Review of the MDS assessment for Resident #117 dated 06/13/25 revealed the resident had severe cognitive and was ambulatory and wandered daily. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan for Resident #117 undated revealed the resident had behavioral problems that included hitting others. Interventions included the following: provide a room change, intervene as necessary to protect the rights and safety of others, approach/speak to the resident in a calm manner, divert the resident's attention, take the resident to an alternate location as needed, monitor behavior episodes and attempt to determine the underlying cause, considering the location, time of day, persons involved, and situation, document the behavior and potential causes. Review of the progress note for Resident #120 dated 04/02/25 at 1:30 A.M. per Licensed Practical Nurse (LPN) #10 revealed staff heard the resident yelling and requesting staff get him/her off of me. LPN #10 observed Resident #120 lying in bed, and their roommate was standing over the resident hitting Resident #120 on the arm with a plastic cup. Resident #120 stated they had also been hit on the left arm and left leg. Review of the progress note for Resident #117 dated 04/02/25 at 1:31 A.M. per LPN #10 revealed Resident #117 was standing over their roommate hitting the roommate on the arm with a plastic medicine cup. LPN #10 asked Resident #117 why they were hitting their roommate and the resident stated they did not know. Review of the Interdisciplinary Team (IDT) note for Resident #117 dated 04/13/25 revealed a resident-to-resident incident occurred. Staff observed Resident #117 standing over their roommate and hitting them with a plastic cup. The note indicated the new behavioral intervention for the resident was a room change. Interview on 08/20/25 at 8:37 P.M. with LPN #10 confirmed on 04/02/25 she heard yelling out from a resident room and found Resident #117 standing at Resident #120's bedside hitting them with a plastic cup. LPN #10 stated she informed the charge nurse and the Director of Nursing (DON) of the resident-to-resident incident. Interview on 08/22/25 at 11:00 A.M. with the DON confirmed the IDT met two times per week to review incidents. She stated that she deferred to the Administrator to decide which incidents should be reported to the SSA. Interview on 08/22/25 at 12:23 P.M. with LPN #9 confirmed she was a night shift team leader, and staff were to report all falls and incidents to her. LPN #9 confirmed she immediately notified the on-call person, the DON or Administrator of resident-to-resident altercations, which required two-hour reporting. She further stated the staff were to write witness statements about the incidents. LPN #9 stated that she did not recall an incident involving Resident #117 in an altercation with another resident Interview on 08/22/25 at 1:58 P.M. with RN #8 confirmed incidents were discussed during IDT meetings, and the Administrator made the decision on which incidents were to be reported to the SSA. She stated that resident-to-resident altercations were to be reported to the SSA within two hours of being notified of them. Interview on 08/22/25 at 3:06 P.M. with the Administrator confirmed the facility did not report the resident-to-resident incident between Resident #120 and #117 to the SSA. Review of the facility policy titled Abuse/Neglect/Misappropriation of Property revised September 2022 revealed the facility would report all allegations of abuse to the SSA. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Number 1301484 (Complaint OH00165616.)		

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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 medical record review, staff interview, facility document review, and review of the facility policy, the facility failed to thoroughly investigate allegations of resident abuse and ensure residents were protected from further potential abuse during the course of the investigation. This affected two (Residents #156 and Resident #120) of three residents reviewed for abuse. Findings include:1. Review of the medical record for Resident #52 revealed an admission date of 12/26/2023 with diagnoses of schizophrenia and bipolar disorder.Review of the MDS for Resident #52 dated 05/21/25 revealed the resident had intact cognition. Review of the care plan for Resident #52 dated 04/16/24 revealed the resident had a history of behaviors which included wandering and making inappropriate comments to staff. Interventions included the following: direct staff to assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, offer tasks that divert the resident's attention. Review of the medical record for Resident #156 revealed an admission date of 09/20/23 with a diagnosis of dementia with behavioral disturbances and a discharge date of 05/12/25. Review of the Minimum Data Set (MDS) assessment for Resident #156 dated 05/06/25 revealed the resident had severe cognitive impairment. Review of a progress note for Resident #156 dated 05/01/25 at 7:41 P.M. per Registered Nurse (RN) #14 revealed the the resident's power of attorney (POA) expressed concern about an interaction they reportedly saw between Resident #156 and another resident and asked if the incident was documented. RN #14 told the POA that they could not release any information until they spoke to their supervisor to ensure there were no privacy violations. Review of the progress note for Resident #156 dated 05/02/25 at 12:05 PM revealed the facility held a care conference with a family member to discuss the resident's escalated verbal and physical behaviors. The note did not address any resident-to-resident incidents. Review of the progress note for Resident #156 dated 05/12/25 at 1:21 P.M. revealed the facility held a care conference with the resident's representative where they discussed the resident's care. The note did not address any resident-to-resident incidents. Interview on 08/21/25 at 7:35 P.M. with Resident #156's representative, Resident Representative (RR) #23 confirmed on 04/26/25 at approximately 7:00 P.M. Resident #156 was watching television when Resident #52 approached Resident #156's room door with their pants down. RR #23 stated Resident #52's belt was unbuckled, their pants were unbuttoned, the zipper was down, and the resident's pants were down to the resident's knees. RR #23 stated they intervened before Resident #52 pulled down their (Resident #52's) brief. RR #23 stated they told Resident #52 to leave Resident #156's room, and once Resident #52 left, RR #23 asked Resident #156 what happened. RR #23 stated that Resident #156 told them that Resident #52 was going to show the resident their genitalia. RR #23 stated they went to the nurses' station at approximately 7:00 P.M. and notified the outgoing and incoming nurses of the interaction between Resident #156 and Resident #52. RR #23 stated staff told them they would keep an eye on the residents and would ensure they were separated. RR #23 stated they contacted the facility on 05/01/25 and spoke with an RN to ensure the facility administration was notified of the interaction. RR #23 stated that on 05/02/25 they called and notified a social (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worker who stated they would notify the Administrator. RR #23 stated on 05/02/25, they received a return call from the Administrator, the Director of Nursing (DON), and the Social Services Designee (SSD). RR #23 stated that during the phone call, they informed the facility staff of the incident and requested an in-person meeting. RR #23 stated that on 05/12/25 an in-person meeting was held with RR #23, the Administrator, the DON, the SSD, and the Assistant Director of Nursing (ADON), and RR #23 discussed the incident during the meeting. Interview on 08/22/25 at 10:53 A.M. with RN #14 confirmed RR #23 had mentioned an incident about Resident #52 exposing himself but stated he did not remember whether RR #23 had reported the incident to him. RN #14 further confirmed if RR #23 had reported something to him, he would have notified the Administrator immediately. Interview on 08/22/25 at 10:20 A.M. with RN #8, who was the former ADON, stated she was notified of the incident between Resident #52 and Resident #156 on 05/01/25. RN #8 stated RR #23 had wanted to speak with management regarding an incident between Resident #156 and Resident #52. RN #8 stated she spoke with RR #23 who stated Resident #156 was sitting on their bed watching television when RR #23 witnessed Resident #52 approaching the room with their pants down to their hips. RN #8 that RR #23 reportedly told Resident #52 that it was not their room, and the resident turned and left. Interview on 08/21/25 at 3:49 P.M. with the SSD confirmed during a meeting with RR #23, the Administrator, and the DON on 05/12/25, RR #23 alleged Resident #52 exposed himself to Resident #156. The SSD revealed the meeting was documented in a progress note, but the allegation of possible resident-to resident abuse was not documented. Interview on 08/21/25 at 4:00 P.M. with the DON confirmed she attended a meeting where RR #23 alleged Resident #52 attempted to expose their genitals to Resident #156. Interview on 08/21/25 at 5:14 P.M. with the Administrator confirmed he was the Abuse Coordinator for the facility and recalled a meeting was held regarding Resident #156's behaviors. The Administrator confirmed during the meeting, RR #23 reported that Resident #52 attempted to expose himself to Resident #156 on 04/26/25. The Administrator confirmed the facility did not report the incident to the SSA nor did the facility conduct a thorough investigation to include measures to protect residents during the course of the investigation. 2. Review of the medical record for Resident #120 revealed and admission date of 11/07/24 with diagnoses including chronic obstructive pulmonary disease, Alzheimer's disease, and major depressive disorder. Review of the MDS for Resident #120 date 06/04/25 revealed the resident had severe cognitive impairment and required supervision with activities of daily living (ADLs.) Review of the medical record for Resident #117 revealed and admission date of 03/22/25 with diagnoses including unspecified dementia without behavioral disturbance, adjustment disorder with anxiety, and hypertension. Review of the MDS assessment for Resident #117 dated 06/13/25 revealed the resident had severe cognitive and was ambulatory and wandered daily. Review of the care plan for Resident #117 undated revealed the resident had behavioral problems that included hitting others. Interventions included the following: provide a room change, intervene as necessary to protect the rights and safety of others, approach/speak to the resident in a calm manner, divert the resident's attention, take the resident to an alternate location as needed, monitor behavior episodes and attempt to determine the underlying cause, considering the location, time of (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day, persons involved, and situation, document the behavior and potential causes. Review of the progress note for Resident #120 dated 04/02/25 at 1:30 A.M. per Licensed Practical Nurse (LPN) #10 revealed staff heard the resident yelling and requesting staff get him/her off of me. LPN #10 observed Resident #120 lying in bed, and their roommate was standing over the resident hitting Resident #120 on the arm with a plastic cup. Resident #120 stated they had also been hit on the left arm and left leg. Review of the progress note for Resident #117 dated 04/02/25 at 1:31 A.M. per LPN #10 revealed Resident #117 was standing over their roommate hitting the roommate on the arm with a plastic medicine cup. LPN #10 asked Resident #117 why they were hitting their roommate and the resident stated they did not know. Review of the Interdisciplinary Team (IDT) note for Resident #117 dated 04/13/25 revealed a resident-to-resident incident occurred. Staff observed Resident #117 standing over their roommate and hitting them with a plastic cup. The note indicated the new behavioral intervention for the resident was a room change. Interview on 08/20/25 at 8:37 P.M. with LPN #10 confirmed on 04/02/25 she heard yelling out from a resident room and found Resident #117 standing at Resident #120's bedside hitting them with a plastic cup. LPN #10 stated she informed the charge nurse and the Director of Nursing (DON) of the resident-to resident incident. Interview on 08/22/25 at 11:00 A.M. with the DON confirmed the IDT met two times per week to review incidents. She stated that she deferred to the Administrator to decide which incidents should be reported to the SSA. Interview on 08/22/25 at 12:23 P.M. with LPN #9 confirmed she was a night shift team leader, and staff were to report all falls and incidents to her. LPN #9 confirmed she immediately notified the on-call person, the DON or Administrator of resident-to-resident altercations, which required two-hour reporting. She further stated the staff were to write witness statements about the incidents. LPN #9 stated that she did not recall an incident involving Resident #117 in an altercation with another resident Interview on 08/22/25 at 1:58 P.M. with RN #8 confirmed incidents were discussed during IDT meetings, and the Administrator made the decision on which incidents were to be reported to the SSA. She stated that resident-to-resident altercations were to be reported to the SSA within two hours of being notified of them. Interview on 08/22/25 at 3:06 P.M. with the Administrator confirmed the facility did not report the resident-to-resident incident between Resident #120 and #117 to the SSA nor did the facility conduct a thorough investigation to include measures to protect residents during the course of the investigation. Review of the facility policy titled Abuse/Neglect/Misappropriation of Property revised September 2022 revealed the facility would investigate all allegations of abuse and would ensure residents were protected from further potential abuse during the course of the investigation. This deficiency represents noncompliance investigated under Complaint Number 1301484 (Complaint OH00165616.)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to provide nail care for one (Resident #13) of four residents reviewed who were dependent on facility staff for activities of daily living (ADL). Findings include: Review of the medical record for Resident #13 revealed an admission date of 05/23/22 with diagnoses including dementia without psychotic disturbance, type two diabetes mellitus, blindness to the right eye, and bilateral glaucoma. Review of the care plan for Resident #13 dated 05/05/23 revealed the resident had a self-care performance deficit and staff were to assist with ADLs as needed. Review of the Minimum Data Set (MDS) assessment for Resident #13 dated 07/08/25 revealed the resident had severe cognitive impairment, was dependent on staff for personal hygiene, and had not rejected care during the assessment look-back period. Observation on 08/20/25 at 8:05 A.M. revealed Resident #13's fingernails on both hands were three to four inches long, extending beyond the fingertips. Resident #13's nails were discolored (yellowish), rough, jagged, and there was a brown substance underneath the nails. Interview on 08/20/25 at 8:06 A.M. with Resident #13 confirmed they wanted their fingernails cleaned and trimmed. Interview on 8/20/25 at 8:16 A.M. with Certified Nursing Assistant (CNA) #4 confirmed Resident #13's fingernails were approximately four inches long and dirty, with dried food or another substance underneath the nail. She stated that because the resident had a diagnosis of diabetes, CNAs were not allowed to cut their nails but were expected to clean them daily and document the care in the resident's electronic medical record and on a shower sheet that was submitted to a nurse. Interview on 08/20/25 at 8:28 A.M. with CNA #5 confirmed Resident #13's nails were exceptionally long and dirty with debris underneath. She stated that nails should be cleaned to prevent scratching, infection, fungus, and germs. She stated that she could clean the resident's nails but could not cut them because the resident had diabetes. Interview on 08/20/25 at 9:01 A.M. with Licensed Practical Nurse (LPN) #3 confirmed Resident #13's nails were about four inches long with food underneath. She stated nurses were responsible for nail care, and long, jagged nails increased the risk of skin injury, infection, and skin tears. Interview on 08/20/25 at 9:12 A.M. with the Director of Nursing (DON) confirmed Resident #13's nails were exceedingly long and needed cleaning. She stated that nurses were responsible for cutting residents' nails, and direct care staff were expected to check residents' nails when providing care including baths, showers, and administration of medications. Review of the facility policy titled Bathing and General Hygiene dated April 2025 revealed staff should perform nail care for residents as needed.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review, interview, and facility policy review, the facility failed to prevent a significant medication error that placed 1 (Resident #132) of 1 resident reviewed for insulin administration at risk for hypoglycemia. Specifically, Resident #132 received short-acting insulin (Humalog) instead of long-acting insulin (Lantus) and required transfer to a hospital emergency department for observation. The findings included: Review of the medical record for Resident #132 revealed an admission date of 07/11/25 with diagnoses including myocardial infarction, chronic kidney disease, and type 2 diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #132 dated 07/17/25 revealed the resident had intact cognition. Review of the care plan for Resident #132 revealed the resident had diabetes mellitus with diabetic polyneuropathy. Interventions directed staff to administer diabetes medication as ordered by clinicians. Review of the physician's orders for Resident #132 revealed an order dated 07/11/25 for Lantus insulin subcutaneously 95 units at bedtime. Review of the physician's orders for Resident #132 revealed an order dated 07/24/25 for Humalog insulin 15 units with meals, hold if the blood sugar is below 150. Review of the progress note for Resident #132 dated 07/24/25 at 10:08 P.M. revealed Resident #132 was given 60 units of Humalog instead of 95 units of Lantus by mistake. Staff called the resident's physician and the resident showed no signs or symptoms of hypoglycemia. Review of the progress note for Resident #132 dated 07/24/25 at 11:00 P.M. revealed the physician gave an order to send the resident to the hospital for an evaluation. Review of the hospital after visit summary for Resident #132 dated 07/24/25 revealed the resident was seen for an accidental medication error. The hospital performed point of care glucose testing 10 times for Resident #132. Interview on 08/18/2025 at 2:27 P.M. with Resident Representative (RR) #6 confirmed she received a call from a facility nurse reporting Resident #132 had been given the wrong insulin and was being sent to the hospital for observation. Interview on 08/19/25 at 5:45 P.M. with Licensed Practical Nurse (LPN) #2 confirmed on 07/24/25 she mistakenly administered 60 units of Humalog insulin to Resident #132 instead of Lantus insulin. Interview on 08/20/25 at 9:43 A.M. with LPN #1 stated LPN #2 reported the medication error involving Resident #132 immediately and stayed with the resident until emergency medical services (EMS) transported the resident to the hospital. Interview on 08/20/25 at 10:27 A.M. with the Director of Nursing (DON) confirmed LPN #2 reported a medication error with Resident #132 on 07/24/25 in which the resident received Humalog insulin instead of Lantus insulin. Interview on 08/21/25 at 3:59 P.M. with the Medical Director confirmed the facility notified him on 07/24/25 that Resident #132 received the wrong insulin. MD confirmed he gave an order for Resident #132 to be transferred to the emergency department for monitoring in a controlled environment. Review of the facility policy titled Medication Error dated May 2025 revealed medication errors would be prevented and reported. This deficiency represents noncompliance investigated under Complaint Number 2579530.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365772	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Eastgate Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4400 Glen Este Withamsville Road Cincinnati, OH 45245	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to maintain medical records that were complete and accurate. This affected one (Resident #154) of 48 sampled residents. Findings include: Review of the medical record for Resident #154 revealed an admission date of [DATE] with a diagnoses of protein-calorie malnutrition and a discharge date of [DATE]. Review of the Minimum Data Set (MDS) assessment for Resident #154 revealed the resident had severe cognitive impairment. Review of the do not resuscitate (DNR) order form for Resident #154 dated [DATE] revealed the physician signed an order for DNR comfort care indicating staff would not perform cardiopulmonary resuscitation (CPR.) Review of the order recap report for Resident #154 revealed an order dated [DATE] for the resident's code status as DNR comfort care. Review of the social service assessment for Resident #154 dated [DATE] per Social Worker (SW) #12 revealed the resident was a full code. Review of the progress notes for Resident #154 dated [DATE] and [DATE] per Physician #25 revealed the resident was a full code. Interview on [DATE] at 10:49 A.M. with SW #12 confirmed she completed Resident #154's social service assessment on [DATE] and had documented the resident was a full code. SW #12 stated that she did not review the physician's orders prior to completing the social services assessment. She stated it was her error, which resulted in incorrect documentation of the resident's code status. Interview on [DATE] at 2:47 P.M. with Physician #25 confirmed she documented Resident #154's code status in error on [DATE] and [DATE] in the physician progress notes. Physician #25 stated the code status was one of the fields in the electronic notes which was prepopulated. Review of the facility policy titled Medical Records System revised [DATE] revealed the facility would ensure medical records were complete, accurately documented, readily accessible, and systematically organized.		