

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: 365798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Courtyard at Seasons		STREET ADDRESS, CITY, STATE, ZIP CODE 7100 Dearwester Drive Cincinnati, OH 45236	
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 and review of the facility policy, the facility failed to safely serve food in a manner to avoid possible contamination and food borne illnesses. This had the potential to affect all of the residents residing in the facility who received food from the facility kitchen. The facility identified one (Resident #36) who received no nutrition by mouth. The facility census was 42 residents. Findings include: Observation on 09/03/25 at 12:05 P.M. of trays being assembled revealed Dietary Aide (DA) #10 donned gloves, grabbed a tray off the cart, reviewed the tray ticket, and picked up a sandwich off the steam table. DA #10 placed food on the plate using serving utensils and removed and replaced the lid to the heated serving compartment with gloved hands. DA #10 then picked up the next tray, reviewed the ticket, picked up a chicken breast with gloved hands and placed it on a plate. Interview on 09/03/25 at 12:10 P.M. with DA #10 at 12:10 P.M. confirmed he had donned gloves and residents' food (sandwich and chicken breast) directly with his gloved hands after touching multiple surfaces and items in the environment. Observation on 09/03/25 at 12:17 P.M. revealed DA #10 picked up a tray, reviewed a tray ticket, and used tongs to put a sandwich on the counter to cut it in half. DA #10 picked up a knife and held the sandwich with his gloved hand to cut it in half. DA #10 then picked up each half of the sandwich with tongs and placed it on the plate. DA #10 then removed his gloves, washed his hands and applied new gloves. DA #10 pulled the next tray, reviewed the ticket, and put a piece of chicken breast on the counter using tongs. DA #10 then cut the chicken breast using his gloved hand to hold the chicken breast as he sliced it. Interview on 09/03/25 at 12:20 P.M. with DA #10 confirmed he touched the sandwich and the chicken breast directly with his gloved hands while slicing the items. DA #10 confirmed he touched other surfaces in the kitchen before and after touching the residents' food. Interview on 09/03/25 at 12:28 P.M. with Food Service Manager (FSM) #157 confirmed gloves should be changed and proper hand hygiene performed prior to touching any food items during tray line. Review of the facility policy titled Hand Hygiene versus Alcohol Based Hand Rub dated 06/15/16 revealed staff should practice hand hygiene at key points in time to disrupt the transmission of microorganisms to residents after contact with contaminated surfaces even if gloves are worn and after removing gloves. Wearing gloves did not replace hand hygiene).		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff donned appropriate personal protective equipment (PPE) during direct care for residents with orders for enhanced barrier precautions (EBP). This affected one (Resident #50) of three residents reviewed for EBP. The facility also failed to take preventative measures to minimize the risk of legionella per the facility's water management plan. This had the potential to affect all of the residents residing in the facility. The facility census was 42 residents. Findings include: 1. Review of the medical record for Resident #50 revealed an admission date of 08/26/25 with diagnoses including but perforation of intestine, colostomy status, and hypertension. Review of the physician's orders for Resident #50 revealed an order dated 08/26/25 for the resident to be on enhanced barrier precautions related to presence of an ostomy. Observation on 09/03/25 at 8:21 A.M. of colostomy care for Resident #50 per Licensed Practical Nurse (LPN) #30 and Certified Nursing Assistant (CNA) #110 revealed the staff donned gloves prior to care but did not don gowns. Interview on 09/03/25 at 8:30 A.M with LPN #30 confirmed Resident #50 had an order for EBP due to the colostomy. LPN #50 confirmed staff should don a gown and gloves prior to providing direct care to a resident on EBP. LPN #30 confirmed staff had not donned gowns prior to colostomy care for Resident #50. Interview on 09/03/25 at 8:34 A.M with CNA #110 confirmed the aide had not donned a gown prior to assisting with colostomy care for Resident #50. Review of the facility policy titled Enhanced Barrier Precautions-Skilled dated 04/09/24 revealed staff members should wear a gown and gloves when participating in high contact resident care including touching indwelling medical devices for residents with physician's orders for EBP. 2. Review of the facility water management program dated 12/29/17 revealed the facility should conduct regular water testing including visual inspections, checking levels, and checking temperatures to minimize the risk of legionella. Interview on 09/03/25 at 4:00 P.M with Maintenance Assistant (MA) #48 and the Administrator confirmed the facility had no recent concerns with legionella, but the facility had no evidence of recent water testing including checking water temperatures. Review of the facility policy titled Health and Wellness Legionella Disease dated 04/22/25 revealed the facility should use preventative maintenance to quickly identify a potential risk of legionella.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interview, and review of the facility policy, the facility failed to provide a comfortable homelike atmosphere for residents dining in the skilled nursing dining room. This affected six (Residents #3, #12, #15, #21, #27, #38) and had the potential to affect all of the residents residing in the facility with the exception of one facility-identified resident (#36) who did not receive nutrition by mouth. The facility census was 42 residents. Findings include: Observation on 09/02/25 at 4:53 P.M. of dinner in the skilled nursing dining room revealed staff served residents on trays directly from the serving cart. The staff did not remove the plates from the meal trays. Interview on 09/02/25 at 4:55 P.M. with Certified Nursing Assistant (CNA) #104 confirmed resident meals were served on trays and staff did not remove the plates of food, utensils, and beverages from the tray. Observation on 09/03/25 at 12:34 P.M. of lunch in the skilled dining room revealed staff served residents on trays directly from the serving cart. The staff did not remove the plates from the meal trays. Interview on 09/03/25 at 12:35 P.M. with Food Service Manager (FSM) #157 confirmed resident meals were served on trays and staff did not remove the plates of food, utensils, and beverages from the tray. Interview on 09/03/25 at 12:47 P.M. with FSM #157 confirmed the facility policy indicated resident food should be taken off the tray and placed on the table in front of each resident to be served in a homelike style. Review of the facility policy titled Meal Service - Hospitality and Customer Service Standard revealed table settings should include tablecloths or place mats, center pieces, presetting of glassware, china plates and tableware without the tray.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure resident code status was correctly noted in the medical record This affected three (Residents #9, #28, and #31) of 16 residents reviewed for advance directives. The facility census was 42 residents. Findings include: 1. Review of the medical record for Resident #28 revealed an admission date of 12/08/24 with diagnoses including atherosclerotic heart disease, hypertension, major depressive disorder, anxiety disorder, and cardiomyopathy. Review of the paper chart for Resident #28 revealed a signed Do Not Resuscitate (DNR) form dated 12/18/24 indicating the resident's code status was DNR Comfort Care. Review of the Minimum Data Set (MDS) assessment for Resident #28 dated 06/17/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the active physician orders for Resident #28 in the electronic health record revealed an order dated 08/18/25 for the resident to be a full code status. Interview on 09/03/25 at 10:45 A.M. with Licensed Practical Nurse (LPN) #38 confirmed Resident #28 had a current order for a code status of full code and had a signed DNR form in his paper chart. 2. Review of the medical record for Resident #31 revealed an admission date of 10/24/24 with diagnoses including unspecified dementia, type two diabetes mellitus, and hypertension. Review of the paper chart for Resident #31 revealed there was a sticker on the outside of the chart which indicated the resident's code status was DNRCC-A. The chart included a DNRCC form signed by the physician dated 09/01/24. Review of the MDS assessment for Resident #31 dated 05/21/25 revealed the resident required staff assistance with ADLs. Interview on 09/03/25 at 10:15 A.M. with Certified Nursing Assistant (CNA) #90 confirmed she would check the resident's chart if she needed to determine the resident's code status. Interview on 09/03/25 at 10:23 A.M with the DON confirmed the nurse labeled resident charts on admission to reflect the resident's code status. The DON verified Resident #31's chart had a sticker indicating the resident's code status was DNRCC-A, but the resident's correct code status was DNRCC. Review of the facility policy titled Advance Directives dated 04/22/25 revealed upon admission staff would verify resident advanced directives and ensure a signed copy of advanced directive was be kept in resident's chart.		

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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 medical record review, observation and staff interview, facility failed to ensure staff provided the appropriate level of supervision during mealtime. This affected one (Resident #38) of six facility-identified residents who required supervision with meals. The facility census was 45. Findings include: Review of the medical record for Resident #38 revealed an admission date of 08/28/24 with diagnoses including cerebral atherosclerosis, dysphagia, and depression. Review of the physician's orders for Resident #38 revealed an order dated 11/01/24 for a regular diet, pureed texture and nectar fluids consistency. Review of the Minimum Data Set (MDS) assessment for Resident #38 dated 06/05/25 revealed the resident had severe cognitive impairment and required supervision from staff with eating. Review of care plan for Resident #38 dated 06/09/25 revealed the resident was at severe nutritional and hydration risk. The goal of the care plan was for resident to be able to safely and effectively chew and swallow a pureed diet with nectar thick liquids. Review of the physician's orders for Resident #38 dated 06/17/25 revealed the resident's diet was liberalized to include mechanical soft foods for pleasure. Review of the physician's orders for Resident #38 dated an order dated 06/24/25 for staff to provide the resident with assistance with feeding at breakfast daily. Observation on 09/02/25 at 5:03 P.M. revealed Resident #38 was sitting in the dining room at a table by herself facing the wall and exhibited episodes of coughing while eating which grew worse as the meal continued. The Surveyor asked Certified Nursing Assistant (CNA) #104 to check on the resident. CNA #104 sat down and faced the Resident #38 and encouraged the resident to slow down in eating. CNA #104 then assisted Resident #38 to take smaller bites at a slower pace. Interview on 09/02/25 at 5:28 P.M. with CNA #104 confirmed Resident #38 had been sitting where staff could not easily see her and the resident had been coughing while eating. CNA #104 confirmed when she provided supervision to Resident #38 at the Surveyor's request. CNA #104 confirmed staff need to intervene immediately to assist any resident who is coughing while eating. Interview on 09/03/25 at 10:20 A.M. with the Director of Nursing (DON) confirmed Resident #38 had an order for staff to assist the resident with eating for breakfast as resident had greatest difficulty eating on her own soon after waking up. The DON confirmed Resident #38 needed supervision at all meals and the expectation was for aides to be stationed in the dining room during all meals and to monitor all residents eating in the dining room.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure insulin was dated upon opening. This affected one (Resident #31) of six residents who had orders for insulin. The facility failed to ensure expired medications were discarded. This affected one (Resident #54) of 42 residents reviewed for medication storage. The facility census was 42 residents. Findings include: 1. Review of the medical record for Resident #31 revealed an admission date of 11/11/24 with diagnoses including dementia, type two diabetes, and hyperlipidemia. Observation on 09/03/25 at 3:54 P.M. of medication storage with Registered Nurse (RN) #76 revealed the Lantus insulin pen for Resident #31 had not been dated upon opening. Interview on 09/03/25 at 3:55 P.M. with RN #76 confirmed Resident #31's Lantus insulin pen had not been dated upon opening. 2. Review of the medical record for Resident #54, revealed an admission date of 08/26/25 with diagnoses including myoneural disorder, rhabdomyolysis, and type two diabetes. Review of the active physician's orders for Resident #54 revealed an order for oyster shell calcium 500 milligrams (mg) twice daily. Observation on 09/03/25 at 4:01 P.M. of the medication cart with RN #76 revealed the oyster shell calcium for Resident #54 had an expiration date of July 2025. Interview on 09/03/25 at 4:02 P.M. with RN #76 confirmed the oyster shell calcium for Resident #54 was expired and should have been discarded. Review of facility policy titled Medication Storage Standard dated on 12/12/24 revealed the facility will follow state regulations regarding medication storage.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to ensure residents received dental services. This affected one (Resident #43) of three residents reviewed for dental services. The facility census was 42 residents. Findings include: Review of the medical record for Resident #43 revealed an admission date of 09/15/23 with diagnoses which included hereditary idiopathic neuropathy, peripheral venous insufficiency, arthritis, and depression. Review of the admission packet for Resident #43 dated 07/19/23 revealed the resident signed the admission packet which noted the facility would arrange for physician visits as authorized under the agreement for ancillary services prescribed by a physician. Review of the physician's orders for Resident #43 revealed an order dated 08/22/23 for resident to receive ancillary services as needed including dental services. Review of the Minimum Data Set (MDS) for Resident #43 dated 05/20/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Interview on 09/03/25 at 3:37 P.M. with Resident #43 confirmed she had never been offered the opportunity to see a dentist since her admission to the facility. Resident #43 confirmed she had no emergent need for a dentist but felt she needed to have her teeth cleaned and evaluated. Interview on 09/03/25 at 5:11 P.M. with the Administrator confirmed Resident #43 had not been seen by a dentist since her admission to the facility.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents were offered appropriate pneumococcal immunizations. This affected one (Resident #42) of eight residents reviewed for immunizations. The facility census was 42 residents. Findings include: Review of the medical record for Resident #42 revealed an admission date of 11/09/22 with diagnoses including chronic atrial fibrillation, gastrointestinal hemorrhage, and hyperlipidemia. Review of the immunization record for Resident #42 revealed the resident received Pneumovax 23 (PPSV23) on 11/10/22. Review of the Minimum Data Set (MDS) assessment for Resident #42 dated 08/15/25 revealed the resident was cognitively intact and the resident's pneumococcal immunizations were completed. Interview on 09/04/25 at 12:20 P.M with the Director of Nursing (DON) confirmed the facility did not offer Pneumococcal Conjugate Vaccine (PCV)15, PCV20, or PCV21 vaccines to Resident #42 due to accidentally marking his pneumococcal immunizations as complete. Review of the facility policy titled Offering Pneumococcal Vaccine dated 03/06/25 revealed upon admission residents will be assessed for eligibility to receive the pneumococcal vaccines (PCV15, PCV23, and PPSV20) and will be offered within 5 days of admission.		