

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Wellspring Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Evergreen Ridge Drive Cincinnati, OH 45215	
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 and document review, and the Food and Drug Administration 2022 Food Code, the facility failed to ensure meals were prepared and food was stored in accordance with professional standards for food safety. This had the potential to affect 38 residents who received meals from the kitchen. The facility census was 40. 1. A facility policy titled, Sanitation - Dish and Utensil Procedure Guideline, dated 03/19/2019, specified, The following guidelines provides an overview of routine cleaning services and the general frequency of various cleaning tasks. The policy specified, 6. Dishes and utensils shall be air dried before storage. Do not towel dry, and 10. Cutting boards need to be washed and sanitized between each use. Replace cutting boards once they have deep knife marks and are unsanitizable. Color-coated cutting boards are useful for designating boards for raw products verses cook products. A. During the initial tour on 12/01/2025 at 9:11 AM, it was discovered the facility had a main kitchen and also a serving kitchen that was used to serve the residents of the skilled nursing facility (SNF). An observation in the main kitchen on 12/01/2025 at 9:34 AM revealed a shelving unit next to the dish machine with clean items in stacks. The observation revealed each stack had approximately eight items that included a stack of full metal pans for the steam table, a stack of half pans for the steam table, metal quarter pans for the steam table, and approximately four metal soup buckets for the steam table. The observation revealed all items were stacked upside down, with significant moisture in between each pan. An observation on 12/01/2025 at 10:06 AM in the SNF serving kitchen revealed insulated food serving bases and domes used to keep food warm were stacked and wet in between each dome and each base. The observation also revealed trays used to deliver food were stacked, face down, near the dish machine, and wet in between each tray. A return visit to the kitchen and observation on 12/03/2025 at 10:20 AM revealed a shelving unit next to the dish machine with clean items in stacks. The observation revealed upside down stacks of full metal pans, half pans, and quarter pans with significant moisture in between each pan. On 12/03/2025 at 11:38 AM the Dietary Services Manager (DSM) stated the soup bowls and domes were being used while they were still wet. On 12/03/2025 at 5:28 PM the Administrator (ADM) stated kitchen items were supposed to be air dried, and items could not dry properly if they were stacked. On 12/04/2025 at 8:57 AM the Director of Dining Services (DDS) stated it was her expectation that kitchen items were left to air dry. On 12/04/2025 at 9:33 AM the Director of Nursing (DON) stated kitchen items should be fully air dried before they were put away, and items should not be stacked when wet. B. An observation of the facility's kitchen on 12/01/2025 at 9:50 AM revealed three red cutting boards, two blue cutting boards, two yellow cutting boards, and three white cutting boards. The observation revealed the cutting boards had large gouges, primarily in the center area of each board; there was minimal color left in the center of each board due to wearing; and except for the white cutting boards color only remained around the edges of the cutting boards, indicating excessive wearing from deep knife marks and concern that the boards could no longer be properly sanitized. On 12/03/2025 at 10:10 AM the Executive Chef stated the cutting boards appeared to be worn and needed to be replaced. On 12/03/2025 at 5:28 PM the Administrator (ADM) stated staff should be checking the cutting boards weekly for wear and tear, and if there was (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	no color left in the center of the cutting board that was an indicator the cutting boards were worn out. 2. A facility policy titled, Food Preparation - Food Storage Policy, reviewed 08/20/2018, specified, Policy: Food items should be stored following good sanitary practices and local codes and manufacturers specifications. The policy also indicated, 6. Opened products should be completely wrapped or placed into a sealable plastic bag, or container with a tight-fitting lids and labeled and dated. During the initial tour of the main kitchen on 12/01/2025 at 9:46 AM, an observation of large bins containing rice, flour, sugar, and panko were observed to be labeled but not dated with no way to know how long that product had been in the bins. A concurrent observation of the serving kitchen and interview on 12/01/2025 at 9:57 AM revealed a hot dog bun in an opened bag without a label or date and a bagel in an opened bag without a label or date. The observation revealed the Dining Services Manager (DSM) removed both items from the bags and placed them in the trash. The DSM stated it was his expectation for the main kitchen to label all bread products prior to sending them to the serving kitchen, and it was the responsibility of the serving kitchen staff to make sure the bags were sealed. An observation of the walk-in freezer on 12/01/2025 at 10:09 AM revealed an unsealed, opened, and exposed box of beef burgers hamburgers on a shelf. An observation of the serving kitchen on 12/03/2025 at 11:22 AM revealed a half of loaf of white bread and a half of loaf of wheat bread not securely closed. On 12/03/2025 at 11:37 AM, the Dining Services Supervisor (DSS) confirmed the bread was not securely tied closed and should have been. On 12/03/2025 at 5:28 PM, the Administrator (ADM) stated it was her expectation that any food item opened in the kitchen should be labeled and dated. The ADM stated bread should be tightly sealed if it was not being used. The ADM stated if the box of hamburgers in the freezer was stored open it could potentially be contaminated. On 12/04/2025 at 8:57 AM, the DDS stated the facility had a procedure for labeling and dating food. The DDS stated food should be closed and sealed, and everything should have a received and opened date on it. The DDS stated bread was audited often, and that was not the first time bread had been found left open. The DDS stated everything in the freezer should be closed and sealed. On 12/04/2025 at 9:33 AM, the Director of Nursing (DON) was interviewed. The DON stated there was a normal expectation that food needed to be closed and stored under ServSafe (a food and beverage safety training and certificate program) regulations and state regulations. 3. Chapter Two of the FDA [Food and Drug Administration] 2022 Food Code titled Hygienic Practices specified, 2-402 Hair Restraints - 2-402.11 Effectiveness. (A) Except as provided in paragraph (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. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostess, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. A facility policy titled, Personal Hygiene - Personal Hygiene Policy, reviewed 08/20/2018 specified, Policy: Guidelines for personal hygiene to promote a sanitary and safe department. The policy continued, Procedure - 1. Head Covering Worn a. Wear a clean hat or other hair restraint in all kitchen production/food service areas. Hair must be appropriately restrained per state regulations. b. Head covering must be clean. C. Beards or any body hair that may be exposed must be covered. The policy also indicated, 3. Clean hands and Fingernails a. Hands must always be washed prior to beginning work. b. Hands must always be washed after smoking, using the restroom, or handling and any unsanitary items. A. An observation during the initial tour of the skilled nursing facility's (SNF) serving kitchen on 12/01/2025 at 9:11 AM revealed the Dining Services Manager (DSM) had facial hair without any covering in the food preparation area. An observation during the initial tour of the main kitchen on 12/01/2025 at 9:25 AM revealed the Executive Chef was observed to have facial hair without any covering in the food preparation area. On 12/03/2025 at 10:12 AM, during a concurrent interview with the Executive Chef and the DSM, the Executive Chef stated he had never been asked (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure care was provided in a dignified manner for one (Resident #43) of one resident reviewed for urinary catheter management. Specifically, the facility failed to ensure Resident #43's urinary catheter drainage bag was covered and urine in the bag was not visually exposed. The facility census was 40. A facility policy titled, Skilled Promoting/Maintaining Resident Dignity, dated 09/10/2025, indicated, It is the practice of this facility to protect and promote resident rights and treat each resident in a manner and in an environment that maintains or enhances the resident's quality of life by recognizing each resident's individuality. A facility policy titled, Urinary Catheter Care, dated 09/08/2013, indicated, Catheter bag should not be visible when in public areas. A catheter bag/cover should be utilized to maintain privacy and dignity. An admission Record revealed the facility admitted Resident #43 on 10/15/2025. According to the admission Record, the resident had medical history that included diagnoses of acute kidney failure and neuromuscular dysfunction of the bladder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/22/2025, revealed Resident #43 had severe impairment in cognitive skills for daily decision-making and had a short term and long term memory problem per the staff assessment of mental status (SAMS). The MDS indicated the resident was dependent with toileting hygiene and had an indwelling urinary catheter. Resident #43's Care Plan Report, included a problem statement, initiated 10/26/2025, that indicated the resident had an indwelling urinary catheter due to a neurogenic bladder. Interventions directed staff to provide catheter care per the facility's policy, 10/26/2025. An observation on 12/01/2025 at 1:48 PM revealed Resident #43 seated in a wheelchair near the doorway to their room with an indwelling urinary catheter drainage bag attached to the wheelchair. Resident #43's indwelling urinary catheter drainage bag contained urine, was visible from the hallway, and did not have a privacy cover. During a concurrent observation and interview on 12/01/2025 at 2:02 PM, Certified Nursing Assistant (CNA) #13 stated Resident #43 arrived from the hospital without a privacy cover on their urinary catheter drainage bag. CNA #13 stated she could see Resident #43's catheter drainage bag from the hallway and staff were expected to place privacy covers on the urinary catheter drainage bags that were visible from the hallway. CNA #13 stated she would obtain a privacy cover. During a concurrent observation and interview on 12/01/2025 at 2:08 PM, Registered Nurse (RN) #14 stated she could see Resident #43's catheter drainage bag from the hallway. RN #14 stated Resident #43's urinary catheter drainage bag was not expected to be visible from the hallway. RN #14 stated the CNAs were responsible for maintaining privacy covers on the resident's urinary catheter drainage bags. During an interview on 12/01/2025 at 2:12 PM, Family Member #15 stated Resident #43 was admitted to the facility on [DATE] and had not had a privacy cover on the catheter drainage bag since their admission. During an interview on 12/03/2025 at 1:22 PM, the Director of Nursing (DON) stated the catheter drainage bag should have been in a privacy cover at all times. The DON stated Resident #43 returned from the hospital without a privacy cover, and staff should have replaced the privacy bag upon admission. The DON stated she made rounds daily and should have identified any catheter drainage bags without privacy covers. The DON stated Resident #43's uncovered catheter bag could be seen from the hall. During an interview on 12/03/2025 at 2:32 PM, the Administrator (ADM) stated residents who preferred their doors open should be offered a privacy cover for their catheter drainage bag.		

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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 observation, interview, record review, and facility document and policy review, the facility failed to ensure fingernails were clean and trimmed for one (Resident #26) of one resident reviewed for activities of daily living. The facility census was 40. A facility policy titled, Skilled - Nail Care, dated 09/10/2025, revealed, 3. Routine cleaning and inspection of nails will be provided during Activities of Daily Living (ADL) care on an ongoing basis. The policy continued, 5. The resident's plan of care will identify: a. The frequency of nail care to be provided. b. The type of nail care to be provided. An admission Record revealed the facility admitted Resident #26 on 03/08/2025. According to the admission Record, the resident had a medical history that included diagnoses of contracture of the right hand, adjustment disorder, and mild cognitive impairment. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/28/2025, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident did not have a history of rejecting care, which included ADL assistance. The MDS indicated Resident #26 required substantial or maximal assistance with personal hygiene. Resident #26's Care Plan Report included a focus area, revised 09/18/2025, that indicated the resident had an ADL self-care performance deficit. Interventions directed staff to check nail length, trim nails, and clean nails on bath days and as necessary (initiated 04/03/2025). Resident #26's Plan of Care (POC) Response History, dated 12/03/2025, revealed personal hygiene was provided by staff every day for the last 30 days. An observation on 12/01/2025 at 10:31 AM, revealed Resident #26's fingernails appeared to be about one half inch long. A concurrent observation and interview on 12/03/2025 at 1:35 PM, revealed Resident #26's fingernails appeared to be about one half inch long with a brown substance under the nails. Resident #26 stated they would let someone cut their nails, the nails did not bother the resident, but the nails did need to be trimmed. Resident #26 stated the nails did not bother them when the nails were dirty, but it probably should. Resident #26 stated they would like someone to clean their nails and cut them. During a concurrent observation and interview on 12/03/2025 at 1:40 PM, Certified Nursing Assistant (CNA) #3 stated nail care was provided when showers were provided, and Resident #26 was showered twice a week. CNA #3 went to Resident #26's room, looked at the resident's fingernails, and stated the resident's nails needed to be trimmed and had dirt under them. During a concurrent observation and interview on 12/03/2025 at 1:48 PM, the Director of Nursing (DON) stated CNAs and nurses provided nail care when residents were showered or whenever nail care was needed. The DON went to Resident #26's room, looked at the resident's fingernails, and stated the resident's nails were too long and they were dirty. The DON stated that she expected residents to have their nails trimmed when needed and to be clean. The DON stated the nurses were responsible for monitoring that nail care was provided. During an interview on 12/03/2025 at 4:25 PM, the DON stated the facility did not have shower sheets, and the DON would have to review the schedule to determine who provided showers for Resident #26. The DON stated that she could not tell if or when showers were provided by reviewing the documentation on the Electronic Medical Record (EMR) as all personal care was checked off under one category and was not divided into different categories for nail care and showers. During a concurrent interview on 12/04/2025 at 10:17 AM, the Administrator (ADM) stated that the CNAs were responsible for monitoring residents' fingernails when showers were provided. The ADM stated that she expected the CNAs to keep the residents' fingernails trimmed and clean. The DON stated Lead CNA #4 provided Resident #26's shower on 11/27/2025, CNA #5 provided Resident #26's shower on 11/24/2025, CNA #6 provided Resident #26's shower on 11/20/2025, and CNA #7 provided Resident #26's shower on 12/02/2025. During an interview on 12/04/2025 at 12:03 PM, Lead CNA #4 stated nail care was provided to residents on shower days. Lead CNA #4 stated she did not provide nail care to Resident #26 during their shower on 11/27/2025 and did not remember if the resident's nails were long or dirty.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview, record review, and facility document and policy review, the facility failed to provide proper treatment and care to one (Resident #19) of one resident reviewed for bowel management. Specifically, the facility failed to address Resident #19's lack of a bowel movement for over three days. The facility census was 40. A facility policy titled, Constipation - Skilled, reviewed 07/14/2022, revealed, 1. The staff will be aware that if a resident has not had a bowel movement after three (3) days, further intervention may be necessary. 2. The certified nursing assistance [sic] will be responsible for documenting if the resident had a bowel movement in Point of Care [the electronic medical record, EMR]. This will be addressed at least every shift and PRN [as needed]. 3. Point of Care has triggers that if no BM [bowel movement] documentation has been noted by the certified nursing aide for 3 days, a Clinical Alert will be posted to the nursing dashboard in Point Click care. 4. The licensed staff will be responsible to follow-up with the nursing aide to ensure if no documentation of a BM is accurate. 5. If certified nursing assistant and/or the resident is unable to vocalize if in fact a bowel movement did occur, the nurse will assess the abdomen to determine if abdominal pain or distention is present. An admission Record revealed the facility admitted Resident #19 on 09/17/2020. According to the admission Record, the resident had a medical history that included diagnoses of benign neoplasm (noncancerous tumor) of the colon and unspecified pain. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2025, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required substantial/maximal assistance with toileting hygiene and was always incontinent of bowel. Resident #19's Care Plan Report included a focus area, initiated 10/22/2025, that indicated the resident had constipation related to decreased mobility and receiving opioid (narcotics for pain) medications. Interventions directed staff to: monitor medications for side effects of constipation and keep the physician informed of any problems (initiated 10/22/2025); monitor, document, and report as needed signs and symptoms of constipation (initiated 10/22/2025); and record bowel movement patterns each day in the EMR and indicate the amount and consistency (initiated 10/22/2025). Resident #19's Order Summary Report, contained an order, dated 11/21/2025, for senna (a laxative) one tablet by mouth one time a day for constipation. The Order Summary Report also contained an order, dated 11/16/2021, for Bisacodyl suppository (a rectally administered laxative) insert one suppository rectally every 24 hours as needed for constipation. Resident #19's Bowel POC [Plan of Care] Response History, indicated the resident had a continent bowel movement on 11/27/2025 and next had an incontinent bowel movement on 12/03/2025 at 12:09 AM, six days later. Resident #19's 11/2025 and 12/2025 Medication Administration Records (MARs) revealed documentation that indicated the resident's Senna was administered once daily as ordered; however, the MARs contained no documented evidence that staff administered the resident's as-needed Bisacodyl during the timeframe the resident had no bowel movements. During an interview on 12/03/2025 at 9:15 AM, Resident #19 stated they thought it had been a week since they had a bowel movement, and they did not feel like they should have to tell the staff. Resident #19 stated the staff were supposed to chart Resident #19's bowel movements and keep up with the resident's condition. Resident #19 stated that the staff should have known the resident was constipated by looking at the resident's chart, and the resident had not told anyone that the resident's stomach felt bruised. Resident #19 stated they felt like it was constipation that caused their stomach to feel bruised. During an interview on 12/03/2025 at 9:01 AM, Certified Nursing Assistant (CNA) #11 stated if a resident had a bowel movement then it should be documented in the EMR. CNA #11 stated if a resident had not had a bowel movement in two to three days then she would notify the nurse. CNA #11 stated she had been out of the facility for the last five days and was unsure when Resident #19's last bowel movement was. CNA #11 stated the nurse would be able to check for the resident's last bowel movement, and the resident had not complained of any stomach pain. During (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview and concurrent observation on 12/03/2025 at 9:29 AM, Licensed Practical Nurse (LPN) #10 stated bowel movements were documented by the CNAs in the EMR, and the Director of Nursing (DON) was responsible for checking the EMR to see if residents had bowel movements within three days. LPN #10 opened Resident #19's EMR, and an alert was seen on the screen indicating the resident had not had a bowel movement in three days. LPN #10 stated she could not see when the resident's last bowel movement was, and she did not see the alert the day before. LPN #10 stated the DON had not told her about the alert, but the DON usually did. During an interview and concurrent observation on 12/03/2025 at 9:46 AM, the Assistant Director of Nursing (ADON) stated the CNAs documented every bowel movement and would report to the nurse if a bowel movement was abnormal. The ADON stated if a resident had not had a bowel movement in three days then an alert on the EMR would notify staff that the resident had not had a bowel movement. The ADON stated she and the DON received the alerts, checked the alerts daily, and were responsible for monitoring the alerts. The ADON reviewed Resident #19's EMR and stated she was unable to see when the resident's last bowel movement was, but that the nurses should have been able to see it. The ADON stated she could see the alert on Resident #19's EMR that indicated the resident had not had a bowel movement in over three days, and the alert had not been cleared. The ADON stated Resident #19 had an order for senna that was scheduled and administered as ordered. The ADON stated Resident #19 had an order for a suppository that had not been administered. During an interview at 12/03/2025 at 10:42 AM, the DON stated she expected the nurses to ask residents when their last bowel movement was, and if the residents were not able to verbalize then to check the residents' charts. The DON stated the CNAs should document every bowel movement on the EMR. The DON stated if a resident had gone longer than three days without having a bowel movement, the nurse should notify the doctor. The DON stated if a resident went without a bowel movement longer than three days an alert would pop up on the EMR, and the ADON checked the dashboard for alerts every day. The DON stated the nurses were able to see the alerts, but the expectation was for the ADON and DON to check the alerts. The DON stated the nurses were responsible for monitoring that residents had bowel movements, and the ADON was responsible for monitoring the alerts. The DON stated that LPN #10 told her that Resident #19 had a bowel movement on Monday, 12/01/2025, and Tuesday, 12/02/2025. The DON stated she did not ask Resident #19 when their last bowel movement was, and the last bowel movement documented on the EMR was on 11/27/2025. The DON stated there should have been an alert on the EMR three days prior, 11/30/2025. The DON checked her computer and stated there was an alert at that time. The DON stated that when the alert appeared, the ADON should have followed up with the nurse and aides to verify if the documentation was correct, and, if the documentation was correct, the physician should have been notified. During an interview on 12/04/2025 at 10:26 AM, the Administrator (ADM) stated that she expected staff to immediately chart bowel movements and follow-up if a resident had not had a bowel movement in three days. The ADM stated nurses were responsible for monitoring bowel movements, and CNAs were expected to document every shift.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Wellspring Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Evergreen Ridge Drive Cincinnati, OH 45215	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure effective coordination between facility staff, the provider, and the pharmacy regarding a refill for a narcotic medication for one (Resident #19) of five residents reviewed for pharmacy services. As a result, the pharmacy was unable to fill Resident #19's prescription for as-needed oxycodone (a narcotic pain reliever), and the resident did not have access to the medication for seven days. The facility census was 40. A facility policy titled, Unavailable Medications - Skilled, revised 04/02/2024, revealed, Policy: When medications or treatments are unavailable, the community should make every effort to obtain the medication or treatment for the resident prior to the scheduled dose. The policy also revealed, 2) Upon notification that a medication or treatment is unable to be supplied by the Preferred Pharmacy, the back up Pharmacy, or the resident/legally responsible party, the Director of Nursing, Administrator or designee should: a) Contact the pharmacy or resident/legally responsible party as appropriate and explore available options to get the medication or treatment delivered as soon as possible, and document all conversations/calls. b) Notify the physician to explore alternative options and document the follow-up instructions in the resident's Progress Notes in the EHR [Electronic Health Record]. An admission Record revealed the facility admitted Resident #19 on 09/17/2020. According to the admission Record, the resident had a medical history that included diagnoses of contracture of the right lower leg muscle, osteoarthritis, unspecified pain, and dorsalgia (back pain). An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2025, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident took an opioid (narcotic, pain medication) medication. Resident #19's Care Plan Report included a focus area, revised 09/08/2025, that indicated the resident had chronic pain related to generalized pain, neuropathy (nerve damage), hypertension (high blood pressure), congestive heart failure, arthritis, and lumbar stenosis (narrowing of the spinal canal. Interventions directed staff to administer pain medication as ordered and to give before treatments or care as indicated (initiated 03/24/2021). Resident #19's Order Summary Report, with active orders as of 12/04/2025, contained a verbal order, dated 11/16/2025 for oxycodone HCL (oxycodone hydrochloride), 5 milligrams (mg) by mouth every eight hours as needed for pain. The Order Summary Report also contained an order, dated 05/10/2024, for acetaminophen (Tylenol) 325 mg two tablets by mouth every six hours as needed for general pain, do not exceed 3000 mg in 24 hours. Resident #19's Medication Administration Record (MAR), dated 11/2025, revealed oxycodone 5 mg was administered to the resident on 11/01/2025, 11/03/2025, 11/04/2025, 11/05/2025, 11/08/2025, 11/09/2025, 11/10/2025, 11/11/2025, 11/13/2025, 11/16/2025, and 11/17/2025. The MAR revealed oxycodone was not administered from 11/18/2025 through 11/23/2025, oxycodone was administered on 11/24/2025, 11/26/2025, 11/27/2025, 11/28/2025, and 11/30/2025. Resident #19's Plan of Care (POC) Response History for the last 30 days revealed: the resident complained of pain on 11/18/2025 at 4:40 AM and 3:26 PM, and the resident had no pain at 7:36 PM; the resident complained of pain on 11/20/2025 at 4:13 PM and the pain was resolved on 8:14 PM; and the resident had no pain on 11/21/2025. A nursing Progress Note[s], dated 11/17/2025 at 5:32 AM, revealed a request for a new prescription for oxycodone was sent to the Medical Director (MD) on 11/16/2025. A nursing Progress Note[s], dated 11/19/2025 at 7:23 PM, revealed a call was placed to the on call medical doctor because a prescription was needed for oxycodone, and the nurse was waiting a callback. A nursing Progress Note[s], dated 11/21/2025 at 5:31 AM, revealed a prescription for oxycodone had not been received, and the nurse faxed a prescription request to the MD. A facility fax transmission record, dated 11/23/2025 at 2:23 PM, revealed a prescription, dated 11/20/2025, for Resident #19 for 75 tablets of 5 mg oxycodone HCL. Two Emergency Kit Authorization Forms, both dated 11/24/2025 and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Wellspring Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Evergreen Ridge Drive Cincinnati, OH 45215	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	untimed, indicated oxycodone was removed from the facility's emergency medication kit twice on 11/24/2025. A pharmacy delivery Manifest, dated 11/25/2025 at 3:51 AM revealed the delivery of 30 oxycodone tablets for Resident #19 to the facility. During an interview on 12/01/2025 at 9:57 AM, Resident #19 stated the facility had run out of their medication for about 10 days. Resident #19 stated they had told the nurses that the resident needed the oxycodone, but the resident did not remember the nurses' names. During an interview on 12/04/2025 at 8:23 AM, Resident #19 stated they had pain on the right side of their body due to having a bad hip. Resident #19 stated they took oxycodone one to two times a day and sometimes took Tylenol. Resident #19 stated the Tylenol was effective for mild pain. Resident #19 stated they were uncomfortable when the facility did not have the resident's opiate pain medication, but the pain was bearable. Resident #19 stated the staff did offer Tylenol, and the resident took that medication. Resident #19 stated they did not feel that they needed to go to the hospital for pain during that time. During an interview on 12/03/2025 at 6:43 PM, Licensed Practical Nurse (LPN) #8 stated if a resident ran out of oxycodone, she would contact the pharmacy to determine if there was a delivery scheduled or if the pharmacy needed a prescription. LPN #8 stated if the pharmacy had a prescription, the pharmacist would provide a code to pull the medication from the emergency kit, but if the pharmacy did not have a prescription, she would not be able to get the medication out of the emergency kit and would call the on-call provider. LPN #8 stated the on-call provider would not provide a prescription for a narcotic. LPN #8 stated that she worked part-time, and Resident #19 ran out of pain medication for about a week around 11/19/2025. LPN #8 stated she called the pharmacy, and the pharmacy did not have a prescription. LPN #8 stated she then notified the on-call provider, and the on-call provider told her they would send a prescription to the pharmacy. LPN #8 stated she called the pharmacy a few hours later, and they still did not have the prescription. LPN #8 stated she was not able to pull the medication from the emergency kit because the pharmacy had not received the prescription. LPN #8 stated she called the on-call provider back and did not receive a call back, and she told Registered Nurse (RN) #8 in report that morning, 11/19/2025, to follow-up. LPN #8 stated she returned to work that Friday night, 11/21/2025, and Resident #19 still did not have any oxycodone. LPN #8 stated she offered Resident #19 Tylenol, but the resident refused because it was not effective. LPN #8 stated the resident looked like they were in pain, because the resident was grimacing. LPN #8 stated she called the on-call provider and did not receive a call back, so she called the Director of Nursing (DON) and notified her of the situation. LPN #8 stated the DON provided LPN #8 a phone number for the Nurse Practitioner (NP), but the NP texted back that the NP was not on-call, so LPN #8 told the DON that she had not received a call back from the on-call providers. During an interview on 12/04/2025 at 8:43 AM, RN #9 stated that sometimes the on-call providers did not call back if it was not considered an urgent matter. RN #9 stated was told in report (information sharing between shifts) by LPN #8, the night nurse, that Resident #19 was out of pain medication. RN #9 stated she did not follow up because the medication was already ordered. RN #9 stated LPN #8 was using the fax machine at the nurse's station, and the MD was not receiving the fax. RN #9 stated a dayshift nurse had emailed the MD, and the MD received the email request. RN #9 stated on the day shift Resident #19 asked for Tylenol, so she gave it to the resident, and she felt like the Tylenol was effective because the resident was very verbal and would have complained if it was not. RN #9 stated that she was off for three days, and when she returned the medication had been refilled. During an interview on 12/04/2025 at 9:28 AM, LPN #10 stated she did not remember the date when Resident #19 ran out of medication, but it was for about a week. LPN #10 stated she was told in report that the MD was on vacation, and the on-call provider would not refill the medication as the on-call providers would not refill narcotics. LPN #10 stated she was then off for a few days, and the medication was refilled when she returned. LPN #10 stated Resident #19 was good about telling her when they were in pain, and the resident told her that they were not in pain. LPN #10 stated Resident #19 also had Tylenol for pain, and that sometimes the resident requested Tylenol and sometimes the resident requested oxycodone. LPN #10 stated Resident #19 did not appear to be in distress while the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Wellspring Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Evergreen Ridge Drive Cincinnati, OH 45215	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxycodone was unavailable. LPN #10 stated she faxed a prescription request to the MD using Documo (cloud-based online fax service). LPN #10 stated Documo seemed to work better than using the fax machine. During an interview on 12/04/2025 at 9:43 AM, the Assistant Director of Nursing (ADON) stated that if a narcotic needed to be refilled then it could be requested by using the reorder tab on the EMR, by faxing the MD using the fax machine, or by faxing the MD using Documo. The ADON stated some of the staff used Documo, but most of the staff just used the fax machine. The ADON stated if it were after hours or on the weekend, the nurse would be able to pull the medication from the emergency kit, but not until a prescription was sent to the pharmacy. The ADON stated there was always an on-call provider, and the on-call provider for the MD should be able to send a prescription for narcotics. The ADON stated nurses could call the ADON or DON but should just call the MD for refills. The ADON stated she was not aware Resident #19 was out of oxycodone for a week. The ADON stated she could see all faxes that were sent via Documo and opened the program on her computer. The ADON stated there was a refill request sent to the doctor on 11/16/2025. The ADON stated that then the pharmacy faxed the facility a prescription on 11/21/2025 at 10:46 AM and requested for the MD to sign it. On 11/22/2025 at 6:56 PM, the MD sent the prescription back to the facility via Documo. The ADON stated the staff would have to check the Documo program to see that the fax was sent by the MD. The ADON stated the staff should always have Documo open and be checking for incoming faxes. The ADON stated the facility did not fax the prescription to the pharmacy until 11/23/2025 at 2:23 PM. The ADON stated the staff must not have checked the fax, and that is why it took so long to send the prescription to the pharmacy. The ADON stated she did not know why the medication was not refilled on 11/16/2025 when it was initially requested. During an interview on 12/04/2025 at 8:30 AM, the Pharmacist stated Resident #19 had an as-needed (PRN) order for oxycodone. The Pharmacist stated that a new prescription for oxycodone was received on 11/23/2025 after the pharmacy was closed. The Pharmacist stated the order was processed on 11/24/2025 and delivered on the morning of 11/25/2025. During an interview on 12/04/2025 at 10:08 AM, the DON stated Resident #19 had Tylenol that could be given. The DON stated she was not aware that Resident #19 was out of oxycodone, and no one had notified her or requested to send the resident to the hospital due to no pain medication being available. The DON stated that if she had been aware that the resident was out of pain medication, she would have contacted the MD herself and followed up. The DON stated that she and the ADON were responsible for monitoring that medications were refilled. The DON stated that her expectation was that if a medication needed refilled, the floor nurse would notify the ADON or DON, put in a progress note, and contact the on-call provider. The DON stated the on-call providers for the MD would not refill narcotics, and narcotics would not be available if a resident needed them after hours or on the weekend if the MD was not available. During an interview on 12/04/2025 at 10:43 AM, the MD stated if the facility needed narcotics refilled, they would fax the request to him. The MD stated that he checked his faxes every evening, and the pharmacy could call him for an emergency three-day supply. The MD stated his on-call providers would forward any narcotic refill request to him. The MD stated that it did not make sense for Resident #19 to be out of medication for that long, and he only remembered being told that the resident's medication had been refilled. The MD stated that he was in the building twice a week, and no one told him anything. The MD stated Resident #19 did need the medication, and the pharmacy should have contacted him for a three-day supply. The MD stated the pharmacy never contacted him. During an interview on 12/04/2025 at 10:20 AM, the Administrator (ADM) stated that the nurses were responsible for monitoring that narcotics were refilled. The ADM stated that she expected the nurses to check and manage the medications and expected a quicker turnaround time from the doctors.		