

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365946	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2025
NAME OF PROVIDER OR SUPPLIER St. Theresa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7010 Rowan Hill Drive Cincinnati, OH 45227	
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)		
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure the residents had had access to their personal funds outside of normal business hours and on weekends. This affected one (Resident #9) of one resident reviewed for personal funds.</p> <p>Findings included:</p> <p>Review of Resident #9's admission record revealed Resident #9's admission date was 05/25/23. Review of the annual Minimum Data Set (MDS) assessment date 04/04/25 revealed Resident #9 had intact cognition.</p> <p>During an interview on 06/11/25 at 10:12 A.M., Business Office Manager #100 stated she believed residents went to the front desk during the week from 8:00 A.M. to 8:00 P.M. to request money from their personal funds from either Receptionist #12 or Receptionist #13.</p> <p>During an interview on 06/11/25 at 10:23 A.M., Receptionist #12 stated the hours the residents could receive money from their personal fund was Monday through Friday from 8:00 A.M. to 5:00 P.M. Receptionist #12 stated on the weekends, the residents knew they could not obtain any of their money.</p> <p>During an interview on 06/11/25 at 11:35 A.M., Resident #9 stated they used to have a problem with getting money with Former Administrator #140 and it typically took at least three days to get any of their requested money. Resident #9 stated they had not asked for money outside of business hours because they knew they could not get it if they wanted or needed it.</p> <p>During an interview on 06/13/25 at 11:22 A.M., the Administrator stated she expected the residents to have access to their personal funds seven days a week.</p> <p>Review of the facility policy titled Transactions Involving Resident Funds dated 07/01/23 revealed the Business Office Manager, or his/her designee, is responsible for providing residents with receipts for withdrawals and for requested or needed personal items when such funds are withdrawn from the resident's personal funds account managed by the facility. The policy did not address when residents should have access to their personal funds accounts or how personal funds were made available to residents after hours and on weekends.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162377.</p>		

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the Resident #176's medical record revealed an admission date of 05/21/25. Diagnoses included rheumatoid arthritis, chronic pain syndrome, and fibromyalgia. The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #176 had intact cognition.</p> <p>Review of Resident #176's care plan revealed a focus area initiated 05/21/25, indicating the resident was at risk for alteration in their comfort related to generalized pain, discomfort, fibromyalgia, chronic pain, depression, and rheumatoid arthritis. Interventions directed staff to administer analgesia per orders and to anticipate the resident's need for pain relief and to respond immediately to any complaints of pain.</p> <p>Review of the SRI dated 05/27/25 revealed Resident #176's family expressed to hospital staff that a facility staff member was rough and verbally mean to the resident. The facility notified the State Survey Agency of the allegation of physical and emotional/verbal abuse on 05/27/25 at 3:59 P.M.</p> <p>During an interview on 06/10/25 at 2:50 P.M., the Director of Nursing (DON) stated when she assessed Resident #176's skin on 05/23/25, the resident reported that on the previous night shift, the staff were rough when they repositioned them. The DON stated she treated this allegation more like a grievance rather than an abuse allegation because she thought it was more related to resident care. The DON stated when Resident #176 was at the hospital a few days later, their family member voiced concerns to the hospital case manager related to abuse and care received in the facility on 05/23/25. Per the DON, once the hospital staff notified the facility of the abuse allegation on 05/27/25, the facility reported the allegation of abuse to the State Survey Agency.</p> <p>During a follow-up interview on 06/13/25 at 10:09 A.M., the DON stated she expected staff to report any allegation of abuse immediately. The DON stated she did not feel like Resident #176's concern of staff being too rough with them was an allegation of abuse because of the resident's history having pain. The DON thought it was more of a care concern and that staff needed to take their time when they repositioned the resident.</p> <p>During an interview on 06/13/25 at 10:34 A.M., the Administrator stated she expected all staff to report any allegations of abuse or neglect, then she had two hours to submit the initial report to the State Survey Agency. When Resident #176 reported to the DON that the night shift staff were rough with them, she followed up with the resident and addressed their concerns. The Administrator stated the resident used the key word rough but did not allege abuse the previous night, so they did not report the allegation. The Administrator stated that when the hospital notified her that Resident #176 alleged facility staff were physically rough with them, that was when they submitted the initial report to the State Survey Agency.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Abuse, Neglect and Exploitation with a copyright date of 2025, indicated the facility will have written procedures that included reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: a. Immediately, but not later than two hours after the allegation is made, if the event that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00166090, OH00164707, and OH00162351.</p> <p>Based on staff interview, record review, review of the facilities Self-Reported Incidents (SRI), and facility policy review, the facility failed to timely report allegations of physical and/or emotional abuse to the State Survey Agency. This affected three (Residents #7, #176, and #276) of five residents reviewed for abuse. The facility census was 80.</p> <p>Findings included:</p> <p>1. Review of Resident #7's medical record revealed an admission date of 04/21/23. Diagnoses included Alzheimer's disease, dementia with agitation, dementia with psychotic disturbance, and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was independent in cognitive skills for daily decision making.</p> <p>Review of the Resident #7's progress notes, electronically signed by Licensed Practical Nurse (LPN) #5 and dated 03/04/25 at 7:38 A.M., indicated the resident was attacked by another resident (Resident #276) with an eye glass case on the right side of their head. Resident #7 was heard screaming and stated, I just got hit with eye glasses by this [man/woman] (Resident #276) standing next to me. Resident #7 was immediately assessed and no injury was noted, but the resident complained of pain to the right side of their head and as needed Tylenol (treats mild pain) was administered as requested. The physician, resident family, and management were made aware.</p> <p>Review of Resident #276's medical record revealed an admission date of 03/08/24 with a diagnosis of chronic obstructive pulmonary disease. The quarterly MDS assessment dated [DATE] revealed Resident #276 had severe cognitive impairment.</p> <p>The progress note, electronically signed by LPN #5 and dated 03/04/25 at 7:16 A.M., indicated Resident #276 walked to another resident (Resident #7) and attacked them with an eye glass case in the head. LPN #5 immediately assisted Resident #276 to a different location and educated the resident not to hit other residents with an eye glass case. The physician, resident family, and management were made aware.</p> <p>Review of the facility's SRI from 03/04/25 to 06/11/25 revealed the facility did not report the physical abuse allegation between Resident #276 and Resident #7 to the State Survey Agency.</p> <p>During an interview on 06/12/25 at 9:36 A.M., LPN #5 stated that on the day of the incident (03/04/25), Resident #7 sat in the television room and yelled at Resident #276. Resident #276 responded to Resident #7 by hitting them on their head with their eyeglasses case. LPN #5 stated she reported the incident to risk management immediately after the incident occurred.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/12/25 at 1:25 P.M., Former Administrator #140 stated he did remember the incident between Resident #276 and Resident #7. Former Administrator #140 stated Resident #7 was very territorial and always had to feel in charge. Former Administrator #140 stated he believed the incident had been reported to the State Survey Agency.</p> <p>During an interview on 06/12/25 at 10:38 A.M., the Administrator verified the facility had not submitted a facility-reported incident to the State Survey Agency following the incident between Resident #276 and Resident #7 on 03/04/2025.</p> <p>During an interview on 06/13/25 at 10:10 A.M., the Director of Nursing (DON) stated the management team was initially told that if two cognitively impaired residents did not know what they were doing and had an altercation, the facility could just separate the residents involved and do nothing further. The DON stated she learned any time there was a physical altercation between two residents even if the residents were cognitive impaired, the altercation had to be reported. The DON stated her expectation was any sort of perception of abuse by a staff member or resident-to-resident, no matter how big or small, the allegation would be reported immediately.</p> <p>During a follow-up interview on 06/13/25 at 10:36 A.M., the Administrator stated the time frame to report an allegation of abuse was immediately or within two hours.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, review of Self-Reported Incidents (SRI) and time cards, and facility policy review, the facility failed to immediately protect the resident(s) from the alleged perpetrator(s) when a resident reported an allegation of staff-to-resident physical abuse. This affected one (Resident #176) of five residents reviewed for abuse.</p> <p>Findings included:</p> <p>Review of the Resident #176's medical record revealed an admission date of 05/21/25. Diagnoses included rheumatoid arthritis, chronic pain syndrome, and fibromyalgia. The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #176 had intact cognition.</p> <p>Review of Resident #176's care plan revealed a focus area initiated 05/21/25, indicating the resident was at risk for alteration in their comfort related to generalized pain, discomfort, fibromyalgia, chronic pain, depression, and rheumatoid arthritis. Interventions directed staff to administer analgesia per orders and to anticipate the resident's need for pain relief and to respond immediately to any complaints of pain.</p> <p>Review of the SRI dated 05/27/25 revealed Resident #176's family expressed to hospital staff that a facility staff member was rough and verbally mean to the resident.</p> <p>Review of time cards for the timeframe 05/22/25 to 05/27/25 revealed Certified Nursing Assistant (CNA) #3 worked in the facility from 7:14 P.M. on 05/22/25 to 7:19 A.M., on 05/23/25, from 8:05 P.M. on 05/23/25 to 7:16 A.M. on 05/24/25, and from 6:51 P.M. on 05/24/25 to 7:00 A.M. on 05/25/25.</p> <p>Registered Nurse (RN) #4's time cards for the timeframe 05/22/25 to 05/27/25 revealed RN #4 worked in the facility from 6:55 P.M. on 05/22/25 to 7:21 A.M. on 05/23/25 and from 7:09 P.M. on 05/24/25 to 7:18 A.M. on 05/25/25.</p> <p>During an interview on 06/10/25 at 2:50 P.M., the Director of Nursing (DON) stated when she assessed Resident #176's skin on 05/23/25, the resident reported that on the previous night shift, the staff were rough when they repositioned them. The DON stated she treated this allegation more like a grievance rather than an abuse allegation because she thought it was more related to resident care. The DON stated when Resident #176 was at the hospital a few days later, their family member voiced concerns to the hospital case manager related to abuse and care received in the facility on 05/23/25. Per the DON, once the hospital staff notified the facility of the abuse allegation on 05/27/25, the facility reported the allegation of abuse to the State Survey Agency, suspended CNA #3 and RN #4 and began an investigation.</p> <p>During a follow-up interview on 06/13/25 at 10:09 A.M., the DON stated she expected staff to report any allegation of abuse immediately. The DON stated the facility should protect the resident following an allegation of abuse, and the facility should immediately suspend the alleged perpetrator pending investigation. The DON verified CNA #3 and RN #4 were not immediately suspended following the initial allegation on 05/23/25 but were suspended once the facility was notified by the hospital of the allegation on 05/27/25. The DON verified CNA #3 and RN #4 worked in the facility between 05/23/25 and 05/27/25 but did not work with Resident #176.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/13/25 at 10:34 A.M., the Administrator stated she expected all staff to report any allegations of abuse or neglect. When Resident #176 reported to the DON that the night shift staff were rough with them, she followed up with the resident and addressed their concerns. The Administrator stated the resident used the key word rough but did not allege abuse the previous night, so they did not report the allegation. The Administrator stated that when the hospital notified her that Resident #176 alleged facility staff were physically rough with them, that was when they suspended CNA #3 and RN #4 and started the investigation.</p> <p>Review of the facility policy titled Abuse, Neglect and Exploitation, with a copyright date of 2025, under Protection of Resident, the facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to responding immediately to protect the alleged victim and integrity of the investigation and make room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00166090 and OH00162351.</p>		