STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365946	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Theresa Care Center	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure a dignified dining experience. This affected three (#60, #4 and #68) of three residents reviewed for dignity during meal service. The facility census was 76. Findings include:1. Review of Resident #60's medical record revealed an admission date of 09/09/21. Diagnoses included dementia, dysphagia and respiratory failure.Review of the Minimum Data Set, (MDS) assessment, dated 10/26/25, revealed Resident #60 had severely impaired cognition and was dependent on staff for eating.Additional review of the medical record revealed Resident #60 received a puree consistency diet and resided on the memory care unit. 2. Review of Resident #4's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia and dysphagia.Review of the MDS assessment, dated 12/18/25, revealed Resident #4 had severely impaired cognition and was dependent on staff for eating. Additional review of the medical record revealed Resident #4 received a puree consistency diet and resided on the memory care unit. 3. Review of Resident #68's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia and encephalopathy. Review of the MDS assessment, dated 01/06/26, revealed Resident #68 had severely impaired cognition and required staff assistance for eating. Additional review of the medical record revealed Resident #68 received a puree diet and resided on the memory care unit. Observation on 01/08/26 at 12:45 P.M. of the memory care unit dining room revealed Resident #60, Resident #4 and Resident #68 were sitting at the same dining room table with lunch meal trays in front of them. Continued observation revealed Certified Nursing Assistant (CNA) #600 was standing while providing eating assistance to Resident #60, Resident #4 and Resident #68.Interview on 01/08/26 at 12:45 P.M. with CNA #600 verified she stood while providing eating assistance to Resident #60, Resident #4, and Resident #68. CNA #600 confirmed she should sit beside the residents when providing assistance with eating. CNA #600 further stated she stood because she would not have been able to reach all three residents if she sat with them. Interview on 01/08/26 at 12:55 P.M. with the Director of Nursing (DON) confirmed CNA #600 should have sat with Resident #60, Resident #4, and Resident #48 while providing eating assistance. The DON further stated it was a resident dignity concern when staff stood over a resident while providing eating assistance. Review of the facility policy titled, Resident Dignity and Feeding Practices, undated, revealed the staff should sit at eye level with the resident.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a facility submitted Self-Reported Incident (SRI), review of staff timecards and schedules, review of a police report, staff interview and policy review, the facility failed to prevent potential abuse following an allegation of staff to resident verbal abuse. This affected one (#30) of three residents reviewed for abuse. The facility census was 76.Findings include:Record review for Resident #30 revealed this resident was admitted to the facility on [DATE]. Diagnoses included lack of coordination, Type II diabetes, and anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 01/06/26, revealed Resident #30 had intact cognition, as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Resident #30 was assessed to require setup or clean up assistance for eating, oral hygiene, and dressing, supervision or touching assistance for toileting and personal hygiene, and partial to moderate assistance for showers/bathing. Review of a facility submitted SRI, created 12/24/25 at 9:49 P.M., revealed on 12/24/25, Resident #30 alleged Licensed Practical Nurse (LPN) #126 threatened to harm her under his breath. Resident #30 called the police and the Administrator to report the alleged verbal abuse. The resident reported to the police that they did not need to further pursue the incident due to the resident feeling safe and the notification to the Administrator. The SRI revealed LPN #126 was put on suspension due to the pending investigation. The Administrator spoke on the phone to Resident #30, LPN #126, and the responding police officer. Review of the police report revealed Resident #30 called the police on 12/24/25 at 8:32 P.M. and the police arrived to the scene at 12/24/25 at 8:57 P.M. Review of the timecard punches revealed LPN #126 clocked in on 12/24/25 at 6:59 P.M. and clocked out on 12/25/25 at 7:18 A.M. Review of the staffing schedules revealed LPN #126 did not work on 12/25/25, 12/26/25, 12/27/25, 12/28/25, 12/29/25, and 12/30/25. Interview on 01/08/26 at 10:49 A.M. with the Administrator confirmed she spoke with Resident #30 about the verbal abuse allegations involving LPN #126 on 12/24/25, prior to the police arriving at the facility. The Administrator verified LPN #126 was not suspended immediately, pending outcome of the investigation into the allegation, and LPN #126 finished his shift on another floor. The Administrator stated LPN #126 was suspended for six days at the end of his shift on the morning of 12/25/25. The Administrator confirmed LPN #126 was allowed to finish his shift after the allegation was made due to not feeling as he was a threat. Review of the facility policy titled, Residents Right to Freedom From Abuse, Neglect, and Exploitation, dated 2025, revealed in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility shall prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in process. This deficiency represents non-compliance investigated under Complaint Number 2702171.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, resident and staff interviews, review of Resident Council and Food Committee meeting minutes, observation of a meal test tray, and review of facility policy, the facility failed to ensure meals were served at palatable temperatures. This had the potential to affect all residents, except two (#1 and #5) identified by the facility as receiving no food from the kitchen. The facility census was 76.Findings include: Observations on 01/07/26 at 2:47 P.M. of the kitchen revealed the plate warmer equipment was not fully functional. Further observation revealed the hot plate pellet system only had one side of the equipment in service and could hold approximately 30 plates at a time. Interview on 01/07/26 at 2:47 P.M. with [NAME] #300 verified the plate warmer equipment was not fully operational and only one side of the equipment worked. [NAME] #300 stated the equipment had not worked for several months and was not aware of any repairs pending completion. Interview on 01/07/26 at 2:50 P.M. with Dietary Manger (DM) #500 verified the plate warmer equipment had not been in service for several months and was unaware of any plans to repair it. DM #500 stated hot foods should be at least 135 degrees Fahrenheit (F) when served to the residents. DM #500 verified there were resident complaints during the November Food Committee meeting and there were ongoing resident complaints regarding hot food temperatures being cold.Interview on 01/08/26 at 8:50 A.M. with Resident #49 revealed the facility food was not hot enough.Observation on 01/08/26 at 12:45 P.M. of a lunch meal test tray revealed the following temperatures: chicken was 112 degrees F, potatoes were 113 degrees F, and the carrots were 114 degrees F. The food items were not hot when tasted.Interview on 01/08/26 at 1:32 P.M. with Resident #35 revealed the meals served by the facility were not hot enough.Interview on 01/08/26 at 1:40 P.M. with Resident #34 revealed food was not hot when it was served.Interview on 01/08/26 at 2:00 P.M. with Resident #21 revealed meals were cold when served.Review of the Food Committee Meeting minutes dated 09/23/25 revealed the residents in attendance voiced concerns related to hot food temperatures being cold. Review of the Resident Council Meeting minutes dated 11/21/25 revealed residents voiced concerns related to hot food temperatures being cold.Review of the facility policy titled, Temperatures of Safe Food Handling, dated 2023, revealed all hot foods should be served hot at 135 degrees F or higher.This deficiency represents noncompliance investigated under Complaint Number 2665253.