STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366023	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Towers	5343 Hamilton Avenue Cincinnati, OH 45224

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, review of facility policy, and review of online guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to thoroughly assess a resident's skin and failed to identify pressure ulcers (injuries to skin and underlying tissue caused by prolonged pressure, friction, or shear, usually over bony areas like the hips, heels, or tailbone) until they had reached an advanced stage. This resulted in Actual Harm for Resident #66 on 02/16/26, when the resident was admitted to the facility without pressure ulcers, was assessed to be at high risk for development of pressure ulcers and developed an avoidable unstageable pressure ulcer (a full-thickness wound where damage depth is hidden by slough [a soft, moist, yellow or white devitalized tissue comprised of dead cells, fibrin, and bacteria that forms in the wound bed, acting as a significant barrier to healing by stalling the inflammatory phase] or eschar [a thick, dry, black or brown layer of dead tissue that forms over deep wounds] making an accurate stage assessment impossible and an unstageable pressure area signifies a deep stage III or IV ulcer requiring urgent medical attention) to the right heel. An additional Harm situation occurred for Resident #76 on 02/15/26, when the resident was admitted to the facility without pressure ulcers, was assessed to be at high risk for development of pressure ulcers and developed a stage III pressure ulcer to the right heel. This affected two Residents (#66 and #76) of the two residents reviewed for pressure ulcers. The facility census was 61.Findings include: 1. Review of the medical record for Resident #66 revealed an admission date of 07/23/23. Diagnoses included Alzheimer's disease, pulmonary embolism (PE), difficulty walking, muscle weakness, and fracture around internal prosthetic joint. Review of the plan of care for Resident #66 dated 07/03/24, revealed the resident was at risk for impaired skin integrity related to impaired physical mobility, moisture from incontinence, and thyroid disease with the goal for the resident's skin to remain intact without pressure ulcer development. Interventions included the following: monitor skin at least weekly and prn for any area of concern and notify the physician for treatment, provide measures to decrease pressure/irritation to skin (pressure reducing mattress and pressure reducing cushion), monitor turning and repositioning, if in the same position for greater than two hour period, cue and or assist to turn, and inform the physician of any complications/adverse changes. Review of the physician order dated 07/04/24, revealed Resident #66 was ordered to have bilateral lower extremities, heels and ankles offloaded with pillows every shift. Review of the physician order dated 07/05/24, revealed Resident #66 was ordered to have weekly skin assessments completed on Fridays during the night shift (7:00 P.M. to 7:00 A.M.). Review of the most recent Braden Scale for Predicting Pressure Sore Risk for Resident #66 dated 10/04/25, revealed the resident was at high risk for the development of pressure ulcers. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the October, November, and December 2025, and January and February 2026, Treatment Administration Records (TAR) for Resident #66 revealed no documentation the facility off-loaded/floated the bilateral lower extremities, ankles and heels on 01/20/26, 02/01/26, 02/08/26 and 02/17/26. The TAR indicated on 02/13/26, Licensed Practical Nurse (LPN) #610 documented on the weekly skin assessment, that Resident #66 no skin impairments identified. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #66 had moderate cognitive impairment and was always incontinent of bowel and bladder, had no range of motion due to impairment in both upper and lower extremities and required a wheelchair for mobility. The resident was dependent on staff for activities of daily living (ADL). Resident #66 was assessed as being at risk for the development of pressure ulcers and did not have an unhealed pressure ulcer/injury. Review of the nurse's progress notes for Resident #66 from 02/01/26 through 02/16/26, revealed no documentation regarding any wound on resident's right heel. Review of the shower sheets for Resident #66 dated 02/13/26 at 6:15 A.M. and 02/15/26 at 6:45 A.M. revealed no new documented skin issues. Review of a weekly skin assessment for Resident #66 on 02/13/26 authored by LPN #610, revealed no skin impairment was identified. Review of the nurse's progress note for Resident #66 dated 02/16/26 at 4:15 P.M. and authored by Registered Nurse (RN) #350, revealed the resident had a black area on the right heel which appeared to be pressure related. There were no open areas or drainage and the skin surrounding the area was intact. The resident complained of pain when the area was touched. Wound Care Nurse Practitioner (WCNP) #900 was notified and ordered for betadine to be applied daily and as needed and leave area open to air with off-loading boots to be applied while the resident was at rest. Betadine was applied per the order with the area left open to air, and off-loading boots applied. Will continue to monitor and report changes. Review of the physician order dated 02/17/26, revealed Resident #66 was ordered to have bilateral heels floated off the bed with pillows as the resident allowed every shift. Review of the nurse's progress note for Resident #66 dated 02/17/26 at 7:00 P.M., revealed RN #600 rounded with WCNP #900 and there was a discolored DTI (a serious pressure-related injury causing damage to underlying soft tissue, presenting as persistent, non-blanchable, deep red, maroon, or purple discolored intact skin or a blood-filled blister) to the resident's right heel and the treatment consisted of betadine and to leave open to air. The measurements were 1.8 centimeters (cm) in length by 2.3 cm width by 0.1 cm width. The resident was ordered to have off-loading boots while in bed, no shoes and only non-skid socks until healed. Review of Skin Evaluation Form assessment for Resident #66 dated 02/17/26, authored by RN #600, revealed the resident had a pressure injury staged as a DTI to the right heel that measured 1.8 cm length by 2.3 cm width by 0.1 cm depth. The treatment consisted of betadine to wound and leave open to air and off-loading boot while in bed. Review of WCNP #900's progress notes for Resident #66 dated 02/17/26, at 11:10 A.M. revealed the resident had an in-house acquired unstageable pressure ulcer of the right heel on 02/17/25 (incorrectly documented by WCNP #900 and should have been 02/16/26) and was located on the right calcaneus. The wound measured 1.0 cm in length by 3.0 cm width by 0.2 cm depth. There was no drainage noted, no granulation within the wound bed, and no necrotic tissue (dead or devitalized cells that cannot be salvaged, appearing as discolored [black, brown, yellow], foul-smelling, or leathery [eschar] tissue) within the wound bed. The peri-wound skin was dry, scaly and discolored DTI. The ordered treatment was to apply betadine and leave open to air (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	and offload heels with off-loading boots, no shoes, and only non-skid socks. Review of the physician order dated 02/18/26, revealed Resident #66 was ordered to have off-loading boots daily while at rest and have betadine applied to left heel and leave open to air. Review of a Skin Evaluation Form for Resident #66 dated 02/24/26 authored by RN #175, who rounded with WCNP #900, revealed Resident #66 had a skin impairment categorized as an unstageable full thickness pressure injury to the right heel that measured 3.0 cm in length by 3.0 cm width by 0.1 cm depth. The tissue was epithelial with no drainage. Review of WCNP #900's progress notes for Resident #66 dated 02/24/26, revealed the resident's wound was classified as unstageable with etiology of pressure ulcer and was located on the right calcaneus. The wound measured 3.0 cm in length by 3.0 cm width by 0.1 cm depth. There was no drainage, no granulation tissue within the wound bed, and a large amount 67 percent (%) to 100% of necrotic tissue within the wound bed, including eschar. The peri-wound was dry/scaly. The treatment was to apply betadine and leave open to air daily and off-load heels with off-loading boots, no shoes, only non-skid socks. The goal and anticipation were that the wound would heal and will be followed weekly. Review of the plan of care for Resident #66 revised on 02/24/26, revealed the resident had an unstageable pressure ulcer to the right heel with the goal to heal the right heel pressure ulcer. Interventions included: treatment to ulcer as ordered, wound care consultation as necessary, weekly skin checks by nurse, pressure reducing mattress to bed, pressure reducing cushion to wheelchair, dietary consultation as needed, and nutritional supplements as ordered. Observation of Resident #66's heels on 02/25/26 at 3:24 P.M. with Certified Nursing Assistant (CNA) #505, revealed Resident #66's right foot had a padded boot in place, the left heel did not, and neither of the resident's heels were being floated to off-load pressure. The resident's right heel had an area the approximate size of a golf ball on the central, right heel and was black in color. During the observation, Resident #66 revealed she experienced pain associated with the area on her right heel, especially during the time when the staff put her socks on and /or removed them. There were soft foam wedges observed sitting on a chair in the resident's room During an interview on 02/25/26 at 3:26 P.M., CNA #505 verified Resident #66's heels were not being floated/off-loaded and should have been. CNA #505 proceeded to place the soft foam wedge in the resident's room under Resident #66's right and left calves to float the heels to off-load pressure. During an interview on 02/26/26 at 11:35 A.M., RN #350 recalled an unknown CNA called her to Resident #66's room on 02/16/26 around 12:00 P.M. because of a skin impairment on the resident's right heel. RN #350 stated the area on Resident #66's right heel was a circular black area, approximately the size of a golf ball, and it was not open or draining. RN #350 revealed she took a picture of Resident #66's right heel wound on 02/16/26 at approximately 12:04 P.M. and sent it to WCNP #900 via the facility phone. RN #350 stated WCNP #900 ordered to have betadine applied to the area and leave open to air. RN #350 verified the wound treatments were not started until 02/18/26. Review of a picture of Resident #66's right heel on 02/26/26 at 11:35 A.M., taken by RN #350 on her dedicated facility phone, revealed the picture was time-stamped on 02/16/26 at 12:04 P.M. The area was round, black and the surrounding skin was red. RN #350 stated she immediately sent the picture to WCNP #900. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 02/26/26 at 1:45 A.M., CNA #575 stated approximately one month ago, Resident #66, complained of pain in the right foot whenever CNA #575 was putting on her socks. CNA #575 was unable to remember if she shared this information with the nurse. During an interview on 02/26/26 at 2:24 P.M. the Director of Nursing (DON), verified Resident #66's right heel wound was discovered on 02/16/26. The DON verified the treatment regimen of applying to betadine to right heel and leaving open to air was ordered on 02/16/26 but not initiated until 02/18/26. During an interview on 02/26/26 at 4:05 P.M., the DON stated skin assessments for Resident #66 were scheduled to be completed every Friday by the nurse and they were supposed to documented on the TAR, and if a skin impairment was identified, it would be documented in the nurse's progress notes. Review of the February 2026 TAR on 02/26/26 at 4:00 P.M. with the DON, revealed Resident #66 had a skin assessment completed on 02/13/26 and no areas of skin impairment were identified. The DON verified if an area of skin impairment was identified on the weekly skin assessment, a progress note would be completed by the nurse completing the skin assessment. During an interview via phone on 02/27/26 at 8:46 A.M., WCNP #900 verified Resident #66's right heel skin impairment was an avoidable unstageable, DTI discovered on 02/16/26. WCNP #900 verified when Resident #66's right heal area opens; it will be visible as a stage III or IV wound bed. Review of the February 2026 TAR for Resident #66, revealed the order for off-loading boots was initiated on 02/18/26 and the treatment was not completed on 02/21/26 and 02/23/26. 2. Review of the medical record of Resident #76 revealed an admission date of 02/10/26. Diagnoses included congestive heart failure (CHF), history of atrial fibrillation, coronary artery disease, and chronic obstructive pulmonary disease (COPD). Review of the nurse's progress note dated 02/10/26 at 11:57 P.M. authored by Licensed Practical Nurse (LPN) #610, revealed the resident was admitted to the facility with no skin issues besides some redness in the groin area. Review of the baseline plan of care for Resident#76 dated 02/10/26, revealed the resident was at risk for impaired skin integrity. Interventions included turning and repositioning every two hours, elevating the heels off the bed, and apply off-loading boots. The resident was to receive showers twice weekly (Tuesdays and Fridays). Review of the Braden Scale for Predicting Pressure Sore Risk for Resident#76 dated 02/11/26, revealed the resident was at high risk for developing pressure ulcers. Review of the Nursing Screen for Resident #76 dated 02/11/26, revealed the resident was admitted with excoriation/reddened area to the groin. No other skin issues were identified. Review of the comprehensive MDS assessment dated [DATE], revealed Resident #76 had intact cognition. The resident was dependent on staff for bed mobility and putting on/taking off footwear, bathing, and toileting. The resident was at risk for pressure ulcers but did not have any pressure ulcers at the time of the assessment. Review of the nurse's progress note for Resident #76 dated 02/15/26 at 12:27 P.M. authored by RN #615, revealed the resident presented with a ruptured blister to the right lateral heel measuring 1.0 cm (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	in length by 3.0 cm in width, and 0.2 cm in depth. A picture of the wound was taken and sent to WCNP # 900. The resident complained of pain in the area. The area was cleansed with normal saline, patted dry, triple antibiotic ointment (TAO) applied was covered with a dried clean dressing. Awaiting a return call from WCNP #900 for ongoing treatment. Review of the nurse's progress note for Resident #76 dated 02/16/26 at 9:05 A.M., revealed a new order was received to apply betadine to the right lateral heel and leave area open to air daily and as needed and off-loading boots while at rest. Review of a physician order for Resident #76 dated 02/16/26, revealed the resident was ordered to have bilateral off-loading boots applied while at rest as tolerated. A physician order dated 02/16/26 and discontinued 02/24/26, revealed the resident was ordered to have betadine applied to the right lateral heel and leave wound open to air. A physician order dated 02/17/26 and discontinued 02/24/26, revealed the resident was ordered to have the right heel cleansed with normal saline, Medihoney applied, and a dry, clean dressing applied. A physician order dated 02/24/26, revealed the resident was ordered to have her right heel cleansed with normal saline, mupirocin two percent applied and a dry clean dressing applied twice a day and as needed. Review of the February 2026 TAR for Resident #76, revealed an order dated 02/16/26 for betadine to be applied to the right heel daily and leave open to air. The treatment was not completed on 02/16/26, 02/17/26, nor 02/20/26. Further review of the TAR revealed an order dated 02/16/26 for off-loading boots while at rest as tolerated upon rising and at bedtime. The order was not completed on 02/16/26 (at bedtime), 02/17/26 (upon rising), 02/20/26 (upon rising), 02/21/26 (at bedtime), and 02/23/26 (at bedtime). Further review of the TAR revealed an order dated 02/19/26 to cleanse the open area to the right heel with normal saline, apply Medihoney (advanced wound dressing to promote healing in chronic and acute wounds) and dry clean dressing daily. The order was not completed on 02/21/26. Further review of the TAR revealed an order dated 02/24/26 to cleanse the open area to the right heel with normal saline, apply Mupirocin 2 % topical ointment and dry clean dressing twice per day. The treatment was not signed off on the night shifts of 02/24/26 nor 02/25/26. Review of WCNP #900's progress notes for Resident #66 dated 02/17/26 at 11:00 A.M., revealed the resident was seen for wound to the right heel which was reported to WCNP #900 as being present on admission. WNP #900 saw the resident in the facility and the staff noted the right heel appeared to have had a blister to the area; however, the wound was open at the time of this visit. WNP #900 assessed Resident #76's right heel to be a stage III pressure ulcer, measuring 1.0 cm in length by 3.0 cm in width by 0.2 cm depth. There was a medium amount of serous drainage (a thin, watery, clear-to-pale-yellow fluid that is a normal part of the early inflammatory stage of healing) noted, large granulation (the growth of new, healthy, red or pink, moist, and bumpy connective tissue and capillaries that fill the wound base) and no necrotic tissue within the wound bed. Orders were to apply Medihoney, apply a low air loss mattress and turn and reposition. Review of a Skin Evaluation Form for Resident #76 dated 02/17/26 at 6:43 P.M. and authored by RN #600, revealed the resident had a stage III pressure injury to right heel that measured 0.0 cm in length by 3.0 cm width by 0.2 cm depth with moderate amount of exudate. The treatment consisted of Medihoney with a dry dressing and apply off- loading boots. Review of the nurse's progress note for Resident #76 dated 02/17/26 at 6:47 P.M., authored by RN #600, revealed she rounded with WCNP #900. The resident had a busted blister to the right heel busted and under the blister was a stage III pressure ulcer with moderate granulation and measured (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1.5 cm in length x 2.0 cm width x 0.2 cm length. Review of shower documentation for Resident #76 revealed the resident refused a shower on 02/17/26 (Tuesday) and received a bed bath on 02/24/26 (Tuesday). There was no documentation about showers being provided to the resident on 02/13/26 and 02/20/26. Review of WCNP #900 progress notes for Resident #66 dated 02/24/26 at 8:20 A.M., revealed WNP #900 saw the resident in the facility and noted the wound was not improving. The area remained classified as a stage III pressure area and measured 2.0 cm in length by 2.5 cm width by 0.2 cm depth. There was a medium amount of serous drainage noted, small amount of granulation, and a large amount of necrotic tissue in the wound bed. The peri-wound was noted with erythema and tender upon palpation and blood-tinged purulent draining. Orders were given to obtain a wound culture, change the treatment regimen to mupirocin ointment twice per day, get a Roho (specialized, air-filled, adjustable pressure-relieving devices designed to prevent skin breakdown, heal pressure ulcers, and improve comfort for individuals with limited mobility) or an air cushion for wheelchair, start the resident on doxycycline (antibiotic) twice daily for seven days and follow-up weekly. Review of a Skin Evaluation Form for Resident #76 dated 02/24/26 at 12:19 P.M. and authored by RN #175, revealed the resident had an unstageable full thickness pressure injury to right heel that measured 2.0 cm in length by 2.5 cm width and 0.2 cm depth. The wound was assessed with eschar, no exudate and treatment consisted of mupirocin ointment and dry dressing twice daily. Observation of Resident #76's right heel on 02/26/26 at 1:00 P.M., revealed a red and beefy area with sloughed skin covering approximately half of the wound. There was a small amount of drainage observed. During an interview on 02/26/26 at 1:17 P.M., RN 305 stated on 02/16/26, she received the order for off-loading boots. RN #305 stated the off-loading boots were ordered on 02/16/26 but not signed off on the TAR until the night of 02/17/26. RN #305 stated offloading boots are readily available in central supply. During an interview on 02/26/26 at 1:46 P.M., LPN #610 verified she completed Resident #76's admission skin assessment on 02/10/26. LPN #610 stated the only concern with Resident #76's skin was some redness to the resident's groin and denied any wounds the resident's heels. During an interview on 02/26/26 at 2:16 P.M., the DON verified the resident only had shower documentation on 02/17/26, which noted the resident refused, and a bed bath on 02/24/26. The DON verified treatments were not signed off as being completed on 02/16/26, 02/17/26, 02/20/26, 02/21/26, 02/23/26, and 02/24/26. The DON verified treatments should have started the same day they were ordered. The DON further verified Resident #76, who was dependent on staff for activities of daily living went from having no pressure ulcer on admission, 02/10/26, to developing a stage III on her right heel on 02/15/26 During an interview on 02/26/26 at 2:24 P.M., RN #615 stated, on 02/15/26, she was the supervisor on duty, and an CNA came to her with a concern about Resident #76's right heel. RN #615 stated she went to look at the resident's heel, and it looked like a ruptured blister. RN #615 stated she measured the area, cleansed it with normal saline, applied triple antibiotic ointment, and covered it with a dry dressing. RN #615 stated she notified WCNP #900 and waited for a response before putting in any new orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 02/27/26 at 11:22 A.M., WCNP #900 stated she documented the blister was present on admission because that is what the facility staff told her. WCNP #900 stated she was contacted on 02/10/26, after the resident was admitted , and the only thing mentioned to her was the redness in the resident's groin and there was no mention of a blister on the resident's heel. WCNP #900 stated her expectation is for treatments to be initiated on admission if areas are present, and for treatments to be initiated as soon as they are ordered. WCNP #900 stated she could not recall if she received a picture of the resident's heel; however, stated she was initially notified the resident had an intact blister but stated it was opened when she saw the resident on 02/17/26. WCNP #900 could not say whether the area was avoidable because she did not know the resident well enough because the resident was new to the facility. WCNP #900 stated it is hard to tell how quickly a blister could form and would depend on whether the area was rubbing against something (like a shoe) or resting on (on a mattress). WCNP #900 stated her expectation is for residents to be bathed twice a week, with the first bathing occurring quickly after admission. WCNP #900 stated the resident's shoes should have been removed right away. Review of facility policy titled, Pressure Ulcer/Injury Prevention and Treatment, dated 11/22/17, revealed the facility would provide care to promote the prevention of pressure ulcer/pressure injury development and promote the healing of existing pressure ulcer/pressure injuries. The definition of an avoidable pressure ulcer/injury revealed avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. Review of the National Pressure Injury Advisory Panel (NPIAP) guidelines, dated 2014, pages 70-71, at (https://npiap.com/general/custom.asp?page=2014Guidelines), revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration. Further review of the guidelines revealed ongoing assessment of the skin was necessary in order to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. Unstageable pressure ulcer is defined as a depth unknown full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, family interview, staff interview, and policy review, the facility failed to ensure resident responsible parties were notified of changes in condition. This affected two Residents (#08 and #12) of the five residents reviewed. The facility census was 61. Review of the medical record of Resident #08 revealed an admission date of 12/08/25. Diagnoses included end-stage renal disease (ESRD), dependence on renal dialysis, chronic obstructive pulmonary disease (COPD), and hypothyroidism. Review of the medical record revealed on 12/09/25, Resident #08 weighed 118.6 pounds (lb.). On 12/13/25, the resident weighed 112 lb. On 12/23/25, the resident weighed 113.6 lb. On 12/31/25, the resident weighed 110.8 lb. On 01/10/26, the resident weighed 109.6 lb. On 01/21/26, the resident weighed 105.4 lb. On 01/01/26, the resident weighed 100.4 lb. On 02/05/26, the resident weighed 98.2 lb. On 02/18/26, the resident weighed 96 lb. On 02/22/26, the resident weighed 94.3 lb. On 02/24/26, the resident weighed 93 lb. Review of the comprehensive Minimum Data Set (MDS) assessment for Resident #08 dated 12/11/25, revealed the resident had moderately impaired cognition. The resident required supervision with eating and partial/moderate assistance with activities of daily living. Review of the medical record revealed no documented evidence of Resident #08's responsible party being notified of Resident #08's weight loss. During an interview on 02/24/26 at 12:52 P.M., Resident #08's daughter stated she was aware her mother was not eating; however, nobody mentioned anything about her weight loss. Resident #08's daughter stated the last weight she was aware of was 115 lb. During an interview on 02/25/26 at 12:22 P.M., Registered Dietitian (RD) #600 stated she relied on the nursing to notify the residents' responsible parties when she has new orders; however, she had no process for notifying responsible parties of weight loss. RD #600 verified there was no documentation in the medical record of Resident #08's responsible party being notified of her significant weight loss. During an interview on 02/25/26 at 12:26 P.M., the Director of Nursing (DON) stated all notifications made by the nursing staff would be documented in the medical record if the notification was completed. Review of the facility policy titled, Notification and Reporting of Changes in Health Status, Illness, Injury, and Death of a Resident, undated, revealed the appropriate associates will promptly inform the resident and resident's representative when there is a change in the residents' health status, including situations of illness, injury, or death. The notification shall include a description of the circumstances and cause (if known). A notification of change in the health status and any intervention taken shall be documented in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366023	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Towers	5343 Hamilton Avenue Cincinnati, OH 45224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and policy review, the facility failed to adequately monitor residents' weights to ensure accuracy of documented weight loss/gain. This affected two Residents (#10 and #12) out of three residents reviewed for nutrition. The facility census was 61. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses of Parkinsonism, cognitive communication deficit, and bipolar disorder.Review of the physician order dated 10/04/24, revealed Resident #10 was ordered to receive a regular diet, regular consistency. Review of the weights for Resident #10 revealed the resident had documented weights on 10/08/25 of 195 pounds (lbs.) and on 11/21/25 of 172.8 lbs. This represented an 11.38 percent (%) weight loss in forty-three days. The resident's next documented weight was on 12/19/25 (204.4 lbs.). Review of the nutrition progress note for Resident #10 dated 11/21/25 and authored by Registered Dietician (RD) #605, revealed Resident #10's current body weight of 172.8 lbs. triggered for a significant weight loss of 11.38 % in the past thirty days and 8.47 % weight loss in the past ninety days. Recommendation of discontinuing Ensure Plus 240 milliliters (ml) and providing Two Cal 240 ml two times a day to provide 950 calories and 40 grams (gm) of protein due to significant weight loss. The physician was notified of the weight loss. There was no recommendation for a re-weight.Review of the weights for Resident #10 revealed the resident had documented weights on 11/21/25 of 172.8 lbs. and on 12/19/25 of 204.4 lbs. This represented an 18.29 % weight gain in thirty days. The resident's next documented weight was on 01/05/26 (204 lbs.). Review of the nutrition progress note for Resident #10 dated 12/19/25 and authored by RD #605, revealed Resident #10's current body weight of 204.4 pounds triggered for a significant weight gain of 18.29 % in the past thirty days. The Two Cal 240 ml two times a day to provide 950 calories and 40 gm of protein remained appropriate due to triggered weight loss last month. Will continue to evaluate the need for supplementation. The physician was notified of weight gain. There was no recommendation for a re-weight.Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE]. revealed Resident #10 had intact cognition and was frequently incontinent of bowel and bladder. The resident required set-up assistance for oral and personal hygiene and bed mobility, and moderate assistance for toileting, bathing, dressing and transfers.Review of the weights for Resident #10 revealed the resident had documented weights on 02/01/26 of 210.8 lbs. and on 02/08/26 of 187.2 lbs. This represented an 11.2 % weight loss in seven days.During an interview on 02/24/26 at 9:55 A.M., Resident #10 stated he was not on a weight loss and/or weight gain plan.During an interview on 02/25/26 at 12:16 P.M., RD #605 verified Resident #12 was on a monthly weight schedule and she reviewed the resident's weights monthly. RD #605 stated if a resident experienced a significant weight gain or weight loss, a re-weight was to be obtained with her expectation that the re-weight be obtained within one week and revealed this was communicated with the nursing department via an email. RD #605 verified Resident #10 had a documented significant weight loss and/or gain and re-weights were not obtained to validate the documented weight loss/gain. During an interview on 02/25/26 at 12:18 P.M., the Director of Nursing (DON) stated it was her expectation that any resident who experienced a documented significant weight gain or weight loss should have obtained a re-weight within two days. Review of the active plan of care for Resident #10 revealed Resident #10 was at risk for nutritional problems with a goal to maintain current body weight plus or minus 3 percent (%) and remain free from significant weight changes. Interventions included to obtain food preferences, diet history (has a selective menu in place to make preferred choices during meal periods), provide supplements as ordered, offer substitutes for food/beverage dislikes or refusal of food/beverages, encourage high protein foods, offer milk with meals to increase protein intake, encourage by mouth intake and assist as needed, monitor adequacy of by mouth intake, evaluate weight record, and provide diet as ordered. 2. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses of Alzheimer's dementia, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	malignant neoplasm of right breast, diabetes mellitus type II, and hypertension.Review of the admission plan of care dated 01/11/25 for Resident #12, revealed the resident was at risk for alteration in nutrition with a goal to maintain current body weight plus or minus three % and remain free from significant weight changes. Interventions included to obtain food preferences / diet history (loves mac and cheese), provide supplements as ordered, offer substitutes for food/beverage dislikes or refusal of food/beverages, encourage high protein foods, offer milk with meals to increase protein intake, encourage by mouth intake and assist as needed, sipper cup with lid for coffee, monitor adequacy of by mouth intake, evaluate weight record, monitor for signs and symptoms of hypoglycemia or hyperglycemia, monitor skin condition/integrity, evaluate nutrition related labs, and provide diet as ordered.Review of the weights for Resident #12, revealed the resident had documented weights on 10/02/25 of 170 lbs. and on 10/06/25 of 182.8 lbs. This represented a 7.53 % weight gain in four days. The resident's next documented weight was on 11/01/25 (192.2 lbs.).Review of the weights for Resident #12, revealed the resident had documented weights on 10/06/25 of 182.8 lbs. and on 11/01/25 of 192.2 lbs. This represented a 5.14 % weight gain in twenty-five days. The resident's next documented weight was on 12/01/25 (180 lbs.). Review of the nutritional assessment for Resident #66 dated 10/15/25 authored RD #605, revealed the resident's current body weight triggered for significant weight gain of 5.18 % in thirty days. The resident had an order for weights to be obtained monthly. The resident had no edema present. The ordered diet was regular with thin liquids.Review of the weights for Resident #12 revealed the resident had documented weights on 11/01/25 of 192.2 lbs. and on 12/01/25 of 180 lbs. This represented a 6.35 % weight loss in one month. The resident's next documented weight was on 01/01/26 (140.2 lbs.). The resident's weight of 192.2 lbs. on 11/01/25 and 176.2 lbs. on 02/01/26 represented a severe weight loss of 8.32 % in three months. Review of the nutrition progress note for Resident #12 dated 11/21/25 authored by RD #605, revealed the resident's current body weight of 192.2 lbs. triggered a significant weight gain of 13.06 % in thirty days and 12 % weight gain in ninety days. The physician was notified of the weight gain. There was no recommendation for a re-weight.Review of the weights for Resident #12 revealed the resident had documented weights on 12/01/25 of 180 lbs. and on 01/01/26 of 140.2 lbs. This represented a 22.11 % weight loss in one month. The resident's next documented weight was on 01/21/26 (177.1 lbs.).Review of the nutrition progress note for Resident #12 dated 12/19/25 authored by RD #605, revealed the resident's current body weight of 180 lbs. triggered for significant weight loss of 6.35 % in thirty days. The physician was notified of wight loss. There was no recommendation for a re-weight.Review of the weights for Resident #12 revealed the resident had documented weights on 01/01/26 of 140.2 lbs. and on 01/21/26 of 177.1 lbs. This represented a 26.32 % weight gain in twenty days. The resident's next documented weight was on 02/01/26 (176.2 lbs.).Review of the MDS Annual assessment dated [DATE], revealed Resident #12 had severe cognitive impairment and was always incontinent of bowel and bladder. The resident required set-up assistance for eating and oral hygiene, and was dependent for personal hygiene, toileting, bathing, and dressing, and required maximal assistance for bed mobility and transfers.Review of the annual nutritional assessment for Resident #12 dated 01/14/26 authored by RD #605, revealed a current body weight of 140.2 lbs. triggered for significant weight loss of 22.11 % for thirty days, 23.30 % weight loss for ninety days, and 19.61% weight loss for six months. The resident had an order for re-weight due to such significant weight loss. The resident received Ensure Plus 240 milliliters (ml) two times a day by mouth to provide 700 calories and 26 grams (gm) of protein in between meals. The unintended weight loss was related to cognitive decline and poor appetite for greater than three months. There were no recommendations to the physician.Review of the documented weights for Resident #12 revealed the re-weight requested on 01/14/26 for Resident #12 was not obtained until 01/21/26 (177.1 lbs.) Review of the nurse's progress note for Resident #12 dated 01/14/26, revealed a new order was received for Resident #12 to be re-weighed. Review of the nutrition progress note for Resident #12 dated 01/15/26 authored by RD #605, revealed a re-weight was requested (for the 01/01/26 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented weight) but was still pending. The physician was notified of the weight loss. Review of the nutrition progress note for Resident #12 dated 02/20/26 authored by RD #605, revealed a current body weight of 176.2 lbs. triggered for a significant weight gain; however, this was pulling from an outlier weight. During an Interview on 02/25/26 at 12:16 P.M., RD #605 verified Resident #12 was on a monthly weight schedule and she reviewed the resident's weights monthly. RD #605 verified if a resident experienced a significant weight gain or weight loss, a re-weight was to be obtained with her expectation that the re-weight be obtained within one week and revealed this was communicated with the nursing department via email. RD #605 verified Resident #12 had a documented significant weight loss of 22.11 % from 12/01/25 to 01/01/26 and Resident #12 was not re-weighed until 01/21/26.During an interview on 02/25/26 at 12:16 P.M., the Director of Nursing (DON) stated it was her expectation that any resident who experienced a documented significant weight gain or weight loss, then the staff should have obtained a re-weight within two days. Review of policy titled, Weights and Weight Change Management, undated, revealed residents will be weighed at least monthly unless otherwise ordered by the physician or recommended by dietician/designee and weight will be documented in the clinical record or in weight monitoring software. Significant weight changes will be addressed by the dietician/designee and interdisciplinary care team. Residents are reweighed if a significant weight loss is noted or to confirm accuracy of weight. The dietician/designee will reassess the nutritional needs and intake of any resident with a significant weight change and make recommendations related to the results of assessment.