STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366053	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkeley Square Retirement Cen	100 Berkeley Drive Hamilton, OH 45013

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review, staff interview, and policy review, the facility failed to ensure food temperatures were documented at the tray line for each meal served from the kitchenettes in the [NAME] and [NAME] Dining Rooms. This had the potential to affect all residents in the facility. The facility census was 27. Findings include:1. Review of facility document titled Trayline Taste & Temperature Log with a revised date of September 2018 revealed that tray line food temperatures were not documented for meals served from the kitchenette in the [NAME] Dining Room for dinner on 03/30/26, dinner on 03/31/26, lunch and dinner on 04/01/26, lunch and dinner on 04/02/26, dinner on 04/07/26, lunch and dinner on 04/08/26, and lunch and dinner on 04/10/26.Interview on 04/13/26 at 9:38 A.M., with the Senior Director of Culinary Services (SDCS) #224 verified the tray line food temperatures were not documented on the Trayline Taste & Temperature Log for meals served from the kitchenette in the [NAME] Dining Room for dinner on 03/30/26, dinner on 03/31/26, lunch and dinner on 04/01/26, lunch and dinner on 04/02/26, dinner on 04/07/26, lunch and dinner on 04/08/26, and lunch and dinner on 04/10/26. 2. Review of facility document titled Trayline Taste & Temperature Log with a revised date of September 2018 revealed that tray line food temperatures were not documented for meals served from the kitchenette in the [NAME] Dining Room for dinner on 04/01/26, breakfast and lunch on 04/02/26, and lunch and dinner on 04/07/26.Interview on 04/13/26 at 9:46 A.M., with the SDCS #224 verified the tray line food temperatures were not documented on the Trayline Taste & Temperature Log for meals served from the kitchenette in the [NAME] Dining Room for dinner on 04/01/26, breakfast and lunch on 04/02/26, and lunch and dinner on 04/07/26.A follow-up interview on 04/15/26 at 3:02 P.M., with the SDCS #224 revealed the revised date for the currently used document titled Trayline Taste & Temperature Log was September 2018.Review of a policy titled Food and Nutrition with an approval date of 09/07/21 revealed, The facility must store, prepare, distribute, and serve food in accordance with professional standards for food service safety.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review the facility failed to document completion of care conferences at the required intervals. This affected two residents (#04 and #15) of 12 residents reviewed for care conferences. The facility census was 27.Findings include:1. Review of the medical record of Resident #04 revealed an initial admission date of 10/14/16 and a re-admission date of 01/31/20. Diagnoses included Parkinson's disease with dyskinesia, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, transient cerebral ischemic attack, type II diabetes mellitus, and major depressive disorder.Review of the most recent significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, did not reject care, and did not wander. The resident was dependent on assistance for all Activities of Daily Living (ADL). Review of Resident #04's medical record revealed an annual MDS assessment was completed on 01/23/25, quarterly MDS assessments were completed on 04/23/25 and 05/16/25, a significant change MDS assessment was completed on 07/16/25, a quarterly MDS assessment was completed on 10/16/25, and a significant change MDS assessment was completed on 01/28/26. Further review of Resident #04's record revealed documentation of care conferences on 04/21/25 and 01/02/26. No additional care conference documentation was available in Resident #04's record.Interview on 04/14/26 at 4:18 P.M. with Unit Care Coordinator (UCC) #155 revealed no additional care conference documentation was available for the last 12 months for Resident #04. UCC #155 confirmed the only care conference documentation for the last 12 months were care conference notes dated 04/21/25 and 01/02/26. UCC #155 reported care conferences should be conducted quarterly with residents and family when possible.2. Review of the medical record of Resident #15 revealed an initial admission date of 10/24/23 and a re-admission date of 12/17/25. Diagnoses included aphasia following unspecified cerebrovascular disease, cerebral infarction, type II diabetes mellitus, unsteadiness on feet, difficulty in walking, coagulation defect, depression, and muscle weakness.Review of the most recent quarterly MDS assessment dated [DATE] revealed the resident had moderate cognitive impairment, did not reject care, and did not wander. The resident was independent for eating, setup assistance for oral hygiene, supervision assistance for upper body dressing, personal hygiene, bed mobility, sit to stand, transfers, walking ten feet, moderate assistance for toileting, bathing, lower body dressing, and mobilizing a manual wheelchair 50 feet.Further record review for Resident #15 revealed a quarterly MDS assessment dated [DATE], an annual MDS assessment dated [DATE], quarterly MDS assessments dated 10/30/25 and 01/09/26 and a quarterly MDS assessment in progress dated 04/10/26. Further record review of Resident #15 revealed a care conference was offered to Resident #15's representative on 08/16/24. It was documented that Resident #15's representative declined to attend this care conference. There was no documentation concerning care conferences in Resident #15's record for the most recent 12 months.Interview on 04/14/26 at 4:18 P.M. with UCC #155 revealed no additional care conference documentation was available for Resident #15 other than the note offering a care conference to Resident #15's representative dated 08/16/24. UCC #155 reported care conferences should be conducted quarterly with residents and family when possible.Review of policy titled Care Conference with a most recent approval date of 06/23/25 revealed the purpose of a care conference was, To review resident's comprehensive plan of care with the resident and/or significant others' participation, when possible. Further review of this policy revealed, The facility will hold periodic care conferences and involve the resident, family, and interdisciplinary team and shall be part of the care planning process.

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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 medical record review, staff interview, and facility policy review, the facility failed to ensure residents received treatment in accordance with professional standards of practice when a resident was not reevaluated for hyperglycemia. This affected one (Resident #03) of five residents reviewed for unnecessary medicine. The facility census was 27.Findings Included:Medical record review revealed Resident #03 had an admission date of 01/05/26. Diagnoses included Alzheimer's, diabetes mellitus type II, and depression Review of the current physician orders for Resident #03 included Humalog (an insulin medication to lower blood sugar) subcutaneous solution pen-injector 100 unit/milliliter (u/ml) per a sliding scale before meals, Lantus (an insulin medication to lower blood sugar) subcutaneous solution pen-injector 25 units daily, and lisinopril (a medication to treat high blood pressure) 5 milligrams (mg) by mouth once daily.Review of the Minimum Data Set assessment completed on 02/04/26 revealed Resident #03 was dependent on staff for transfers from bed to chair, requires substantial/maximal assistance with toileting hygiene, requires supervision/touch assistance with eating, and requires assistance with bathing.Review of Resident #03's progress note created on 04/15/26 at 12:19 A.M. by Registered Nurse (RN) #100 revealed the on call provider was notified of Resident #03's blood glucose level of 532 milligrams per deciliter (mg/dL) and a new order to administer eight additional units of lispro (Humalog) and to recheck the blood glucose in 30 minutes. Review of the electronic medication administration record for Resident #03 revealed a blood sugar level of 532 mg/dL obtained on 4/14/26 at 9:00 P.M. An additional eight units of lispro given on 4/14/26 at 9:21 P.M.Interview with the Director of Nursing (DON) on 4/16/26 at 8:36 A.M. verified there was no evidence in Resident #03's chart the residents blood glucose was re-evaluated after administration of additional insulin. The DON verified per facility policy concerning abnormal blood glucose, the resident should have been re-evaluated.Review of facility policy titled Abnormal Blood Glucose Procedure revised 8/24/16 revealed that signs and symptoms of hyperglycemia will be reported to the attending physician and that the nursing process step of evaluating will be included in progress note documentation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on medical record review, observation, review of the medication regimen review, staff interview, and policy review, the facility failed to ensure the pharmacy recommendations from the monthly drug regimen review by a licensed pharmacist were acted upon. This effected one (Resident #08) of five residents reviewed for medication regimen review. The facility census was 27.Findings Included:Review of the medical record for Resident #08 revealed an admission date of 11/24/25. Diagnoses included Parkinson's, dementia, hypothyroidism. Review of the current physician orders included levothyroxine sodium (a hormone medication to treat the thyroid) tablet 150 microgram (mcg) once a day, buspirone hydrochloride (an antianxiety medication) 50 milligram (mg) by mouth twice a day, and losartan potassium (a medication to treat high blood pressure) tablet 100 mg by mouth once a day.Review of the Minimum Data Set assessment completed on 03/02/26 revealed Resident #08 utilized a walker and wheelchair for mobility and required setup/cleanup assistance with meals.Review of the medication regimen review for Resident #08 dated 11/25/2025 revealed the following recommendation from the consultant pharmacist: Per manufacturer, levothyroxine should be administered consistently in the morning on an empty stomach, at least 30-60 minutes before food. Further review revealed no specific physician response to the consultant pharmacist recommendation.Review of Resident #08's medication administration record for April 2026 revealed levothyroxine was to be given at 9:00 A.M.Observation on 04/16/26 at 8:03 A.M. Resident #08 was eating breakfast in dinning area. Interview on 04/16/26 at 8:28 A.M., with Licensed Practical Nurse (LPN) #150 revealed she gave Resident #08 her levothyroxine 150 mcg to her while she was in the dining area eating breakfast.Interview on 04/16/26 at 8:48 A.M., with the Director of Nursing (DON) verified there was no evidence in Resident #08's medical record as to why or why not the consultant pharmacist recommendation from 11/25/25 was acted upon.Review of facility policy titled Drug Regimen Review dated 10/01/18 revealed a consulting pharmacist shall provide monthly reviews of medications of in-house residents upon admission and monthly and the reviews are sent to nursing and are addressed with the primary care provider or consulting specialist for review and follow-up.