STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366145	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeridge Villa Health Care Center	7220 Pippin Rd Cincinnati, OH 45239

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on medical record review, resident interview, observation, staff interview, review of the facility policy review, the facility failed to ensure residents were able to have private phone conversations. This affected two (Residents #5 and #83) of 18 residents sampled for communication. The facility census was 90 residents. Findings include: 1. Review of the medical record for Resident # 5 revealed an admitted [DATE] with diagnoses including heart failure, chronic obstructive pulmonary disease (COPD), morbid obesity, type two diabetes, and paranoid schizophrenia. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 01/03/25 revealed the resident had moderately impaired cognition. 2. Review of the medical record for Resident # 83 revealed an admitted [DATE] with diagnoses including quadriplegia, incomplete paraplegia, neuromuscular dysfunction of the bladder, adjustments disorder with mixed anxiety and depressed mood, and osteomyelitis. Review of the MDS assessment for Resident #83 dated 11/27/24 revealed the resident was cognitively intact. Interview on 03/03/25 at 10:17 A.M. with Resident #83 confirmed he did not have a phone in his room or a cell phone and had to make all phone calls using the phone at the nurses' station. Resident #83 confirmed using the phone at the nurses' station made him very uncomfortable because there was no privacy, and everyone around could hear his conversation. Interview on 03/03/25 at 2:07 P.M. with Resident #5 confirmed she was unable to have a private conversation on the phone because she had to use the phone at the nurses' station. Resident #5 stated she had reported to staff that this made her very uncomfortable, but nurses told the phone at the nurses' station was the only phone available to the residents. Observation 03/05/25 at 3:43 P.M. revealed the first-floor nurses' station had one telephone at the corner of the station sitting on a ledge that was approximately waist high. Licensed Practical Nurses (LPNs) #38 and #39 were seated behind the nurses' station. (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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/05/25 at 3:44 P.M. with LPNs #38 and #39 confirmed the phone in the first-floor nurses' station was the only phone available to staff and residents at the station. LPN #38 and #39 confirmed when residents were making telephone calls from the phone at the nurses' station, they could hear details of the residents' phone conversations. Further interview confirmed if the situation were reversed, they would not feel comfortable making personal calls from the phone at the nurses' station. LPNs #38 and #39 confirmed they had received complaints from multiple residents including Residents #5 and #83 regarding lack of privacy during telephone conversations. Observation on 03/06/25 at 11:10 A.M. revealed Resident #5 was sitting in front of the nurses' station talking on the facility phone with two nurses and multiple residents nearby. Resident #5 was easily overheard vocalizing her feelings about her day and care received. Review of policy titled Dignity dated February 2021 revealed staff promoted, maintained, and protected resident privacy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, staff interview, and review of the facility policy, the facility failed to notify resident representatives of a change in condition. This affected one (Resident #87) of two residents reviewed for change in condition. The facility census was 90 residents. Findings include: Review of the closed medical record for Resident #87 revealed an admitted [DATE] with diagnoses including Parkinson's Disease, dementia without behavioral disturbance, and schizoaffective disorder. Review of the Minimum Data Set (MDS) assessment for Resident #87 dated 11/07/24 revealed the resident #87 had severely impaired cognition and required staff assistance with activities of daily living (ADLs.) Review of the progress note for Resident #87 dated 01/05/25 revealed the resident had remained in bed for the last two days, refused food, and had minimal fluid intake. The note did not include documentation the resident's guardian had been informed of the change in condition. Interview on 03/06/25 at 11:04 A.M. with the Director of Nursing (DON) confirmed the facility staff had discussed a hospice referral for Resident #87 due to the resident's change in condition, but they did not feel Resident #87 was appropriate yet. The DON confirmed the facility's plan was to obtain labs, but then the resident declined rapidly and passed away. The DON confirmed there was no documentation of notification to Resident #87's guardian regarding the resident's change in condition. Review of the policy titled Change in a Resident's Condition or Status revised February 2021 revealed the facility would promptly notify the resident's representative of changes in the resident's medical condition or status.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51523 Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility staff failed to ensure the accuracy of comprehensive resident assessments. This affected one (Resident #55) of four residents reviewed for comprehensive assessments. The facility had a census of 90 residents. Findings include: Review of the medical record for Resident #55 revealed an admitted [DATE] with diagnoses including end stage renal disease, diabetes, and chronic pulmonary obstructive disease (COPD) Review of the Minimum Data Set (MDS) assessment for Resident #55 dated 01/23/25 revealed the resident required substantial to maximum assistance with toileting, bathing, and upper and lower body dressing. Interview on 03/03/25 at 4:30 P.M. with Resident #55 confirmed he was independent with toileting, bathing, and dressing. Resident #55 further confirmed he had experienced occasional episodes of weakness and fatigue following dialysis and the staff monitored showers if taken after dialysis but never provided hands-on care. Interview on 03/03/25 at 4:35 P.M with Certified Nursing Assistant (CNA) #16 confirmed Resident #55 was independent with toileting, bathing, and dressing. Interview 03/03/25 at 4:52 P.M. with Licensed Practical Nurse (LPN) #38 confirmed Resident #55 was independent with toileting, bathing and dressing and had been so siince admission on 08/20/24. LPN #38 further confirmed Resident #55's MDS dated [DATE] was not accurate regarding the resident's functional status and abilities. Review of the facility policy titled Resident Assessments dated March 2022 revealed all persons who had completed any portion of the MDS must sign a form attesting to the accuracy of the information.

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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** 42492 Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to appropriately revise care plans. This affected one (Resident #85) of three residents sampled for smoking. The facility census was 90 residents. Findings include: Review of the medical record for Resident # 85 revealed an admitted [DATE] with diagnoses including rheumatoid arthritis, unspecified mental disorder, and cognitive communication deficit. Review of the smoking safety evaluation for Resident #85 dated 01/09/25 revealed the resident was able to hold, light, and extinguish a cigarette safely. Review of care plan for Resident #85 dated 01/15/25 revealed the resident had a potential for injury related to smoking cigarettes. Interventions included the following: complete smoking assessments quarterly and with significant change, observe clothing daily for burn holes, secure cigarettes and lighters at the nurses' station, staff to check room regularly for cigarettes and lighters. Review of smoking safety evaluation for Resident #85 dated 01/15/25 revealed the resident had balance problems, had limited range of motion in arms/hands, and followed the facility's smoking policy. Observation on 03/03/25 at 11:16 A.M. revealed Resident #85 had a box of menthol in the pocket of his jacket hanging in his room. Interview on 03/03/25 at 11:17 A.M. with Resident #85 confirmed he was an independent smoker and was permitted to keep his cigarettes and lighter in his coat pocket and could go out to smoke anytime he wanted to do so. Interview on 03/05/25 at 11:19 AM with the Administrator confirmed residents who were deemed safe were permitted to keep smoking supplies on their person and in their rooms, unless otherwise care planned. Interview on 03/05/25 at 12:02 P.M. with the Director of Nursing (DON) confirmed the former Administrator wanted all resident smoking supplies to be kept at the in the nurses' station regardless of the resident's ability to safely smoke independently. The DON confirmed Resident # 85 was independent with smoking and was able to keep his smoking supplies in his room. The DON further confirmed Resident #85's care plan had not been updated to reflect the new policy that independent smokers were able to keep smoking supplies in their rooms. Review of the facility policy titled Smoking undated revealed residents who were deemed unsafe were not permitted to hold smoking materials on their person or in their room. Review of the facility policy titled Care Plan Revisions Upon Status Change dated 2024 revealed care plans were modified as needed by the MDS Coordinator or other designated staff member. (continued on next page)

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	366145	A. Building B. Wing	03/06/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35770 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected one (Resident #53) of five residents observed for medication administration. The facility census was 90 residents. Findings include: Review the medical record for Resident #53 revealed an admitted [DATE] with diagnoses including encephalopathy, depression, anxiety, acute kidney failure, urine retention, and alcohol abuse. Review of the Minimum Data Set (MDS) assessment for Resident #53 dated 02/07/25 revealed the resident had no cognitive deficits and required minimal assistance with activities of daily living (ADLs). Review of the physician's orders for Resident #53 revealed an order dated 08/24/24 for Lexapro 15 milligrams (mg) one time per day. Observation of medication administration for Resident #53 on 03/05/25 at 8:21 A.M. per Licensed Practical Nurse (LPN) #38 revealed the nurse administered Lexapro 7.5 mg to the resident. Interview on 03/05/25 at 11:52 A.M. with LPN #38 confirmed Resident #53's Lexapro order was for 15 mg daily and she had given the wrong dose on 03/05/25 and every day she had worked in January and February 2025. LPN #38 confirmed she had made the same medication error with Resident #53's Lexapro dose on 23 days in January and February 2025. Review of the staffing schedule dated 01/01/25 to 02/28/25 revealed LPN #38 worked on the following 23 days and administered medications to Resident #53: 01/03/25, 01/06/25, 01/08/25, 01/11/25, 01/12/25, 01/17/25, 01/17/25, 01/20/25, 01/29/25, 01/31/25, 02/03/25, 02/08/25, 02/09/25, 02/10/25, 02/12/23/25, 02/26/25, 02/27/25, 02/28/25. Review of the facility policy titled Administering Medications dated April 2019 revealed medications should be administered in a safe and timely manner, and as prescribed.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35770 Based on medical record review, observation, resident interview, and staff interview the facility failed to provide resident diets in accordance with the physician's orders and resident preference. This affected one (Resident #192) of five residents reviewed for food. The facility census was 90 residents. Findings include: Review of the medical record for Resident #192 revealed an admitted [DATE] with diagnoses including diabetes, mild intellectual disability, and bilateral below the knee amputations. Review of the physician's orders for Resident #192 revealed an order dated 02/27/25 for the resident to receive double portions of food due to weight loss. Review of meal ticket dated for Resident #192 dated 03/03/25 revealed the resident was to receive double portions of country chicken and dumplings, peas and carrots, cornbread, and cake. Interview on 03/03/25 at 10:09 A.M. with Resident #192 confirmed he was supposed to be getting double portions on his trays, but he only received small portions, and it was not enough food for him. Observation of Resident #192's dinner tray on 03/03/25 at 4:42 P.M. revealed the tray did not have double portions of any food item. Interviews on 03/03/25 at 4:42 P.M. with Certified Nursing Assistants (CNAs) #05 and #11 confirmed Resident #192 only received single portions at dinner on 03/03/25.

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	366145	A. Building B. Wing	03/06/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51523 Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to ensure staff properly secured their hair while serving resident meals. This affected two (Residents #70 and #1) of 17 residents observed for meal service. The facility census was 90 residents. Findings include: Review of the medical record for Resident #70 revealed an admitted [DATE] with diagnoses including dementia, congestive heart failure, and chronic kidney disease. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including dementia, diabetes mellitus type two, osteoarthritis, and peripheral vascular disease. Observation on 03/05/25 at 5:17 P.M. revealed Licensed Practical Nurse (LPN) #30 was serving meal trays to Residents #70 and #1. LPN #30 had long hair which was unsecured and falling into the residents' meal trays. Interview on 03/05/25 at 5:32 P.M. with LPN #30 confirmed her long hair was unsecured and had fallen onto the plates of Residents #70 and #1. Review of facility policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices undated revealed all employees who served food would be trained in safe food handling practices prior to serving food to residents. Hair nets or caps must be worn to keep hair from coming in contact with residents' food.

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	366145	A. Building B. Wing	03/06/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35770 Based on medical review, observation, staff interview, and review of the facility policy, the facility failed to ensure nurses properly documented administration of narcotic medications. This affected three Residents (#14, #32, and #67) of three residents reviewed for medication reconciliation. The facility census was 90 residents. Findings include: 1.Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including right femur fracture, malnutrition, personality disorder, and anxiety. Review of the controlled substance count sheet for Resident #14 revealed there were three doses of Tramadol remaining. Observation on 03/05/25 at 11:04 A.M. with Licensed Practical Nurse (LPN) #30 revealed there were only two doses of Resident #14's Tramadol in the cart. Interview on 03/05/25 at 11:04 A.M. with LPN #30 confirmed she had given a dose of Tramadol to Resident #14 earlier in the day on 03/05/25 but had not documented administration of the medication. 2.Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses including cerebral infarction, aphasia, anxiety, dementia, and depression. Review of the controlled substance count sheet for Resident #32 revealed there were 12 doses of Ativan remaining. Observation on 03/05/25 at 11:05 A.M. with LPN #30 revealed there were only 11 doses of Resident #32's Ativan in the cart. Interview on 03/05/25 at 11:05 A.M. with LPN #30 confirmed she had given a dose of Ativan to Resident #32 earlier in the day on 03/05/25 but had not documented administration of the medication. 3.Review of the medical record for Resident #67 revealed Resident #67 an admitted [DATE] with diagnoses including cirrhosis, asthma, respiratory disorders, and depression. Review of the controlled substance count sheet for Resident #67 revealed there were 40 doses of Ativan remaining. Observation on 03/05/25 at 11:06 A.M. with LPN #30 revealed there were only 39 doses of Resident #67's Ativan in the cart. Interview on 03/05/25 at 11:06 A.M. with LPN #30 confirmed she had given a dose of Ativan to Resident #67 earlier in the day on 03/05/25 but had not documented administration of the medication. (continued on next page)

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	366145	A. Building B. Wing	03/06/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Storage of Medications dated November 2020 revealed when the nurse should document medication administration in the resident's medical record at the time of administration.

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	366145	A. Building B. Wing	03/06/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42492 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff donned appropriate personal protective equipment (PPE) when providing direct care to residents in enhanced barrier precautions (EBP). This affected one (Resident #83) of three residents observed for EBP. The facility census was 90 residents. Findings include: Review of the medical record for Resident #83 revealed an admitted on 10/03/24 with diagnoses including unspecified quadriplegia, incomplete paraplegia, neuromuscular dysfunction of the bladder, and osteomyelitis. Review of care plan for Resident #83 dated 10/07/24 revealed the resident was in EBP due to active wounds, indwelling catheter, and colostomy. Interventions include to educate the resident and family on use of EBP and proper PPE and to post EBP signage on the resident's door. Review of the Minimum Data Set (MDS) assessment for Resident #83 dated 11/27/24 revealed the resident was cognitively intact. Review of care plan for Resident #83 dated 12/09/24 revealed the resident had an indwelling catheter related to diagnosis of neurogenic bladder. Observation on 03/05/25 at 5:04 P.M. of catheter care for Resident #83 per Certified Nursing Assistants (CNAs) #115 and #20 revealed the aides entered the resident's room wearing face masks and donned clean gloves. Neither aide donned a gown before transferring the resident from the chair to the bed using a Hoyer lift, removing the resident's pants, emptying the resident's catheter bag, performing catheter care, and placing a clean brief on the resident. Interview on 03/05/25 at 5:20 P.M. with CNA #115 confirmed neither she nor CNA #20 donned a gown prior to providing direct care to Resident #83 who was on EBP. Review of the facility policy titled Enhanced Barrier Precautions dated August 2022 revealed employees should don gowns when providing care to a resident on EBP.