STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366153	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace View Gardens	3904 North Bend Road Cincinnati, OH 45211

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) Manual 3.0, the facility failed to timely complete quarterly Minimum Data Set (MDS) assessments. This affected four residents (#44, #76, #14, and #09) out of 24 residents reviewed for MDS assessments. The facility census was 75.Findings include: 1. Medical record review for Resident #44 revealed an admission re-entry date of 03/01/22. Diagnoses include paraplegia, vascular dementia, cognitive communication deficit, type II diabetes mellitus, acute respiratory failure with hypoxia, major depressive disorder, delusional disorder, anxiety disorder, and complete traumatic amputation at level between left hip and knee. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 was cognitively intact. The resident was supervision assistance for eating, and oral hygiene, and maximal assistance for toileting, dressing, and personal hygiene. The resident was documented as rejecting care one to three times over seven days. Further record review for Resident #44 revealed a quarterly MDS assessment with an Assessment Reference Date (ARD) of 03/03/25 and a completion date of 03/18/25. Interview on 02/25/26 at 2:18 P.M. with Licensed Practical Nurse (LPN) #214 verified Resident #44 had a quarterly MDS with an ARD of 03/03/25, an MDS completion date of 03/18/25, and that the MDS was completed late. 2. Medical record review for Resident #76 revealed an admission date of 10/04/23. Diagnoses included Alzheimer's disease, depression, type II diabetes mellitus, unspecified fracture of the lower end of right radius, and major depressive disorder. Review of the most recent quarterly MDS assessment dated [DATE] revealed Resident #76 had moderately impaired cognition. The resident was supervision assistance for all activities of daily living. She was continent of bladder and bowel and demonstrated no challenging behaviors. Further record review for Resident #76 revealed a quarterly MDS assessment with an ARD of 04/11/25 and a completion date of 04/28/25. Interview on 02/25/26 at 2:18 P.M. with LPN #214 verified Resident #76 had a quarterly MDS with an ARD of 04/11/25, an MDS completion date of 04/28/25, and that the MDS was completed late. 3. Medical record review for Resident #14 revealed an admission date of 04/11/25. Diagnoses included Alzheimer's disease, vascular dementia, psychotic disorder with delusions due to known (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physiological condition, type II diabetes mellitus, cerebral infarction, unspecified mood disorder, and anxiety disorder. Review of quarterly MDS assessment dated [DATE] revealed Resident #14 was severely cognitively impaired. The resident required supervision assistance for eating, oral hygiene, dressing, transfers, and ambulation, moderate assistance for toileting, and personal hygiene, and maximal assistance for bathing. The resident was frequently incontinent of bladder and bowel, rejected care one to three times a week, and exhibited wandering behaviors daily. Further record review for Resident #14 revealed a quarterly MDS assessment with an ARD of 10/27/25 and a completion date of 11/11/25. Interview on 02/25/26 at 2:18 P.M. with LPN #214 verified Resident #14 had a quarterly MDS with an ARD of 10/27/25, an MDS completion date of 11/11/25, and that the MDS was completed late. 4. Review of the medical record for Resident #09 revealed an admission date of 05/27/25. Diagnoses included encephalopathy, aphasia, dysarthria and anarthria, orthostatic hypotension, hypertension, atrial fibrillation, cerebral infarction, anxiety disorder, depression, type two diabetes mellitus without complications, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and heart failure. Review of the quarterly MDS assessment for Resident #09 dated 11/13/25 revealed the assessment was not completed until 12/01/25. Resident #09 was identified as having severely impaired cognition. Resident #09 was assessed to require supervision for eating, and bed mobility, partial/moderate assistance for oral hygiene, and substantial/maximal assistance for toileting, bathing, dressing, personal hygiene, and transfer. Interview on 02/25/26 at 2:26 P.M. with MDS Nurse – LPN #214 verified the assessment was not completed until 12/01/25. Review of the Resident Assessment Instrument (RAI) Manual 3.0 revealed quarterly assessments must be completed every 92 days and within 14 days from the ARD.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) 3.0 manual, the facility failed to timely complete comprehensive Minimum Data Set (MDS) assessments. This affected three (#04, #07, and #81) out of 24 residents reviewed for assessments. The facility census was 75.Findings include:1. Review of the medical record for Resident #04 revealed an admission date of 01/16/25. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, other generalized epilepsy and epileptic syndromes intractable without status epilepticus, aphasia following cerebral infarction, iron deficiency anemia, hypertension, cerebral infarction, encephalopathy, vitamin d deficiency, depression, type two diabetes mellitus without complications, hyperlipidemia, hypertensive heart disease without heart failure, and chronic respiratory failure with hypoxia.Review of the annual MDS assessment started on 01/27/26 for Resident #04 revealed the assessment was not completed until 02/12/26. Resident #04 was identified as having severely impaired cognition. Resident #04 was assessed to be dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility, and transfer.Interview on 02/25/26 at 2:25 P.M. with MDS Nurse - Licensed Practical Nurse (LPN) #214 verified the annual assessment was not completed until 02/12/26.2. Review of the closed medical record for Resident #07 revealed an admission date of 12/29/25. Diagnoses included type two diabetes mellitus with other skin ulcer, cellulitis of left lower limb, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, other symptoms and signs involving cognitive functions following other cerebrovascular disease, major depressive disorder, vitamin d deficiency, anxiety disorder, Alzheimer's disease with late onset, chronic kidney disease, congestive heart failure, acute respiratory failure with hypoxia, cellulitis of right lower limb, ischemic cardiomyopathy, moderate protein-calorie malnutrition, metabolic encephalopathy, hypothyroidism, hyperlipidemia, and peripheral vascular disease.Review of the admission MDS assessment for Resident #07 started on 01/09/26 revealed the assessment was not completed until 01/16/26. Resident #07 was cognitively intact. Resident #07 was assessed to require supervision for eating, oral hygiene, and personal hygiene, substantial/maximal assistance for toileting, bathing, and lower body dressing, and partial/moderate assistance for upper body dressing, bed mobility, and transfer.Interview on 02/25/26 at 2:22 P.M. with MDS Nurse - LPN #214 verified the assessment was not completed until 01/16/26.3. Review of the closed medical record for Resident #81 revealed an admission date of 12/23/25. Diagnoses included type two diabetes mellitus with ketoacidosis without coma, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, hyperlipidemia, hypertension, acute kidney failure, edema, and chronic kidney disease.Review of the admission MDS assessment for Resident #81 started on 12/31/25 revealed the assessment was not completed until 01/07/26. Resident #81 was identified as having moderately impaired cognition. Resident #81 was assessed to require supervision for eating, oral hygiene, and personal hygiene, partial/moderate assistance for toileting, bathing, upper body dressing, and bed mobility, and substantial/maximal assistance for lower body dressing, and transfer.Interview on 02/25/26 at 2:21 P.M. with MDS Nurse - LPN #214 verified the assessment was not completed until 01/07/26.Review of the Resident Assessment Instrument 3.0 revealed the MDS admission assessment need completed within 14 days of admission. The annual assessment are required at least every 366 days from the Assessment Reference Date (ARD).

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) 3.0 manual, the facility failed to timely complete significant change Minimum Data Set (MDS) assessments. This affected three residents (#48, #05, and #11) of four residents reviewed for a significant change. The facility census was 75.Findings include: 1.Medical record review for Resident #48 revealed an admission date of 05/23/23. Diagnoses included encephalopathy, dysphagia, aphasia, cognitive communication deficit, dementia, muscle weakness, chronic pulmonary embolism, and diabetes insipidus. Review of the most recent quarterly MDS assessment dated [DATE] revealed the resident had severely impaired cognition. The resident was maximal assistance for eating, and upper body dressing, dependent for oral hygiene, toileting, bathing, lower body dressing, personal hygiene, transfers, and mobility in a manual wheelchair. Resident #48 was incontinent of bladder and bowel. Further review of Resident #48's record revealed a significant change MDS assessment was required due to a decline in the resident's abilities related to several areas under Activities of Daily Living (ADL). This significant change MDS had an Assessment Reference Date (ARD) of 05/09/25 and a completion date of 05/26/25. Interview on 02/25/26 at 2:18 P.M. with Licensed Practical Nurse (LPN) #214 verified the significant change MDS had an ARD of 05/09/2025, a completion date of 05/26/25, and that the MDS was completed late. 2. Medical record review for Resident #05 revealed an admission date of 09/05/25. Diagnoses included Alzheimer's disease, dementia, cognitive communication deficit, anxiety disorder, aphasia, vascular dementia, metabolic encephalopathy and major depressive disorder. Review of the most recent significant change in status MDS assessment dated [DATE] revealed the resident had severely impaired cognition. The resident was supervision assistance for eating, bed mobility, transfers, and ambulating 50 feet or less, moderate assistance for oral hygiene, and personal hygiene, and maximal assistance for toileting, and bathing. Resident #05 was frequently incontinent of bladder and bowel. Further review of Resident #05's record revealed the resident registered with hospice care services on 12/24/25, which triggered a significant change MDS assessment. This significant change MDS assessment had an ARD of 01/05/26 and a completion date of 01/19/26. Interview on 02/25/26 at 2:18 P.M. with LPN #214 verified the significant change MDS had an ARD of 01/05/26 and a completion date of 01/19/26. A follow-up interview with LPN #214 on 02/26/25 at 12:19 P.M. verified the significant change in status MDS assessment was triggered by the resident's election of hospice services. 3. Review of the medical record for Resident #11 revealed an admission date of 09/09/22. Diagnoses included non-active primary progressive multiple sclerosis, dysuria, unspecified protein-calorie malnutrition, hypothyroidism, hyperlipidemia, hypertension, anemia, depression, cataract extraction (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status left eye, and cataract extraction status right eye. Review of the significant change MDS assessment for Resident #11 dated 12/30/25 revealed the assessment was not completed until 01/14/26. Resident #11 was cognitively intact. Resident #11 was assessed to require supervision for eating, and oral hygiene, substantial/maximal assistance for dressing, personal hygiene, and bed mobility, and was dependent on staff for toileting, bathing, and transfer. Review of the physician orders for Resident #11 revealed an order dated 12/17/25 for admission to hospice services. Review of the hospice enrollment form dated 12/23/25 revealed Resident #11 admitted to hospice effective 12/17/25. Interview on 02/25/26 at 2:24 P.M. with MDS Nurse – LPN #214 verified the significant change assessment was not completed until 01/14/26. Review of the Resident Assessment Instrument (RAI) Manual 3.0 revealed a significant change assessment must be completed withing 14 days of identifying the change.

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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** Based on medical record review and staff interview, the facility failed to conduct quarterly care conferences. This affected three (#02, #11, and #68) out of three residents reviewed for care conferences. The facility census was 75.Findings include:1. Review of the medical record for Resident #02 revealed an admission date of 08/01/22. Diagnoses included type two diabetes mellitus without complications, major depressive disorder, hypertension, histoplasmosis, hypothyroidism, hyperlipidemia, anemia, obesity, tachycardia, peripheral vascular disease, post-traumatic stress disorder, anxiety disorder, heart failure, and obstructive sleep apnea.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #02 was cognitively intact. Resident #02 was assessed to require supervision for eating, partial/moderate assistance for oral hygiene, and upper body dressing, substantial/maximal assistance for toileting, bathing, lower body dressing, personal hygiene, and bed mobility, and was dependent on staff for transfer.Review of the care conference documentation for Resident #02 revealed the only documented care conferences were for 02/22/25, 08/25/25, and 02/18/26.Interview on 02/25/26 at 2:56 P.M. with Licensed Social Worker (LSW) #603 verified the only documented care conferences for Resident #02 were for 02/22/25, 08/25/25, and 02/18/26.2. Review of the medical record for Resident #11 revealed an admission date of 09/09/22. Diagnoses included non-active primary progressive multiple sclerosis, dysuria, unspecified protein-calorie malnutrition, hypothyroidism, hyperlipidemia, hypertension, anemia, depression, cataract extraction status left eye, and cataract extraction status right eye.Review of the significant change MDS assessment dated [DATE] revealed Resident #11 was cognitively intact. Resident #11 was assessed to require supervision for eating, and oral hygiene, substantial/maximal assistance for dressing, personal hygiene, and bed mobility, and was dependent on staff for toileting, bathing, and transfer.Review of the care conference documentation for Resident #11 revealed the only documented care conferences were for 06/24/25 and 09/18/25.Interview on 02/25/26 at 2:54 P.M. with LSW #603 verified the only documented care conferences for Resident #11 were for 06/24/25 and 09/18/25.3. Review of the medical record for Resident #68 revealed an admission date of 10/29/22. Diagnoses included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, epilepsy unspecified not intractable without status epilepticus, unspecified atrial fibrillation, depression, hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, sleep apnea, benign prostatic hyperplasia without lower urinary tract symptoms, non-Hodgkin lymphoma, acute pulmonary edema, hyperlipidemia, chronic obstructive pulmonary disease, cardiomyopathy, and takotsubo syndrome.Review of the quarterly MDS assessment dated [DATE] revealed Resident #68 was cognitively intact. Resident #68 was assessed to require supervision for eating, oral hygiene, and bed mobility, substantial/maximal assistance for toileting, dressing, and personal hygiene, and partial/moderate assistance for transfer.Review of the care conference documentation for Resident #68 revealed the only documented care conferences were for 02/22/25 and 07/03/25.Interview on 02/25/26 at 2:58 P.M. with LSW #603 verified the only documented care conferences for Resident #68 were for 02/22/25 and 07/03/25.