

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER Residence at Huntington Court		STREET ADDRESS, CITY, STATE, ZIP CODE 350 Hancock Avenue Hamilton, OH 45011	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and policy review, the facility failed to implement a comprehensive person-centered care plan for hearing aids and hearing loss for a resident. This affected one (Resident #50) of six residents reviewed for care plans. The facility census was 89. Findings include: Review of the medical record revealed Resident #50 was admitted to the facility on [DATE]. Diagnoses included paroxysmal atrial fibrillation and encephalopathy. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #50 had minimal difficulty hearing and hearing aids. The MDS 3.0 assessment dated [DATE] revealed Resident #50 had severely impaired cognition, had moderate difficulty with hearing, and did wear hearing aids. Review of Resident #50's care plan with last revision date of 03/13/26 revealed there was no focus of area of the resident being hard of hearing or wearing a hearing aid. There were no interventions in place for the care and storage of the hearing aid. Interview on 03/23/26 at 10:45 A.M. with the MDS Coordinator #15 confirmed there was no care plan in place for Resident #50's hearing loss with a hearing aid. Interview on 03/24/26 at 11:12 A.M. with the Administrator revealed Resident #50's hearing aids were reported lost on 02/25/26, reordered by facility on 03/02/26 and arrived to the facility for Resident #50 on 03/23/26. Review of the policy titled Care Conference dated 03/20/24 revealed the facility's interdisciplinary team shall periodically review the resident's care plan and make revisions based on the goals, preferences and needs of the resident. This deficiency represents non-compliance investigated under Complaint Number 2802107.</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, the facility failed to ensure proper cleaning of reusable equipment between residents and failed to maintain clean linen storage. This affected Residents #37 and #38 and had the potential to affect the 13 residents residing on the F Hallway. The facility census was 89. Findings include: Review of the medical record revealed Resident #37 was admitted to the facility on [DATE]. Diagnoses included sepsis and sarcoid myocarditis. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 was cognitively intact. Review of the physician orders for Resident #37 dated 03/11/26 revealed an order for enhanced barrier precautions (EBP) due to an indwelling urinary catheter and maintain contact precautions due to Klebsiella Pneumoniae. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE]. Diagnoses included onychogryphosis. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #38 had moderately impaired cognition. Review of the physician orders for Resident #38 dated 03/01/26 revealed an order for EBP due to suprapubic catheter. Observation and interview on 03/18/26 from 10:26 A.M. to 10:46 A.M. revealed Licensed Practical Nurse (LPN) #10 was in Resident #37 and Resident #38's room, LPN #10 obtained vital signs, including pulse oximetry, thermometer and blood pressure cuff from Resident #38 and obtained vital signs from Resident #39 without cleaning the reusable equipment between residents. LPN #10 removed her gown and gloves, attempted to place the PPE in red biohazard bin in the bathroom. LPN #10 stated the bag had fallen down in the red biohazard bin. LPN #10 reached down with ungloved hands and was attempting to find the bag, and there were multiple dirty gowns were in the red biohazard bin. LPN #10 confirmed no gloves were worn when reaching in red biohazard bin and should have been worn. LPN #10 also confirmed she did not clean the reusable equipment between Resident #37 and Resident #38 while obtaining vital signs and should have cleaned them. Observation on the F Hallway and interview on 03/18/26 at 12:04 P.M. with Certified Nursing Assistant (CNA) #11 revealed the three tier linen cart front cover was uncovered with all of the linen open to air. CNA #11 confirmed the front flap should always be down covering all towels and gowns. Observation on the F Hallway and interview on 03/18/26 at 1:29 P.M. with Housekeeping Supervisor #12 revealed he three tier linen cart had a dirty white towel with brown spots sitting on top of the clean linen cart and a dirty bag directly next to the linen cart on floor with gloves and gown inside. Housekeeping Supervisor #12 confirmed the dirty towel on top of the linen cart and the bag of dirty items on the floor directly next to the linen cart. Interview on 03/24/26 at 8:35 A.M. with the Director of Nursing (DON) confirmed the staff should be cleaning all reusable equipment between residents. Review of the policy titled Infection Control dated 11/28/17 revealed gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. Review of the policy titled Infection Control Standard Precautions dated 05/05/17 revealed ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed. This deficiency represents non-compliance investigated under Complaint Number 2719210.</p>		