STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366208	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residence at Huntington Court	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, staff interview, and medical record review, the facility failed to ensure adequate nail care was provided for one (#24) of 18 sampled residents. The census was 90. Findings included: Review of an admission record revealed the facility admitted Resident #24 on 01/10/25 with diagnoses including cerebral infarction due to thrombosis of the right posterior cerebral artery, dementia with agitation, need for assistance with personal care, type II diabetes mellitus, and contracture of the muscle of the left upper arm. Review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/19/25, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated the resident had severe cognitive impairment. The MDS assessment indicated the resident was dependent on staff for bathing and required partial to moderate assistance with personal hygiene. Review of Resident #24's care plan report, included a focus area initiated 01/29/25, that indicated the resident's needs for activities of daily living (ADLs) care ranged from requiring partial assistance to being totally dependent on staff. Interventions directed staff to provide bathing assistance, diabetic nail care, and grooming (including nails) assistance as needed, and to monitor for a decline in care and report to clinical staff as needed. The care plan report also included a focus area initiated 01/29/25, that indicated the resident refused personal care at times. Interventions directed staff to document educational attempts made with the resident. Review of Resident #24's ADL-Bathing record revealed staff documented nail care was provided on 06/14/25 and 06/18/25. The report revealed no documented evidence the resident refused nail care on 06/14/25 or 06/18/25. Review of Resident #25's shower day skin inspection sheet dated 06/14/25, revealed Certified Nurse Aide (CNA) #12 documented Resident #24's fingernails were cleaned. Review of Resident #24's shower day skin inspection sheet, dated 06/18/25, revealed CNA #13 documented Resident #24's fingernails were cleaned. Review of Resident #24's progress notes, dated 06/13/25 through 06/18/25, revealed no evidence to indicate Resident #24 refused nail care on 06/14/25 or 06/18/25. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/17/25 at 11:23 A.M., Resident #24 was observed in bed and the resident's fingernails on the right hand were approximately one-half an inch beyond the nail bed and there was brown matter under each nail. During an observation on 06/19/25 at 8:41 A.M., Resident #24 was in bed and the resident's fingernails on the right hand had brown matter underneath the nail. During a telephone interview on 06/20/25 at 8:28 A.M, CNA #12 stated she provided a bed bath for Resident #24 on 06/14/25. She stated Resident #24 became combative while cleaning the resident's nails and she was only able to clean two nails on the left hand and one nail on the right hand. She stated she notified Licensed Practical Nurse (LPN) #7 that the resident refused nail care but did not document on the shower day skin inspection sheet that she was unable to finish cleaning the resident's fingernails. During a telephone interview on 06/20/25 at 9:39 A.M., LPN #7 stated she remembered CNA #12 told her that she was not able to clean all of Resident #24's nails on 06/14/25; however, she forgot to document the refusal. LPN #7 stated Resident #24 did not like their hands to be touched and would not allow staff to clean their nails on 06/14/2025. During an interview on 06/19/25 at 11:46 A.M., CNA #13 stated on 06/18/25, Resident #24 allowed her to start cleaning their nails but became combative and she was not able to finish cleaning the resident's nails on their right hand. CNA #13 stated she meant to go back to finish the resident's nail care but forgot. During an interview on 06/19/25 at 12:03 P.M., Unit Manager (UM) #9 stated Resident #24 could be very resistant to care. During a concurrent interview and observation on 06/19/25 at 12:09 P.M., UM #9 entered Resident #24's room, picked up the resident's right hand, and stated the resident's nails were long and had some type of substance underneath the nails. UM #9 stated the resident's fingernails definitely needed to be cleaned and trimmed. UM #9 then opened the clenched fingers on Resident #24's left hand and stated the nails could be trimmed. During an interview on 06/19/25 at 11:18 A.M., the Director of Nursing (DON) stated the CNAs needed to clean the residents' fingernails when they were soiled or dirty. The DON stated if the CNA was unable to clean the residents' nails, they should let the nurse know. The DON stated the CNAs and nurses were supposed to sign the shower day skin inspection sheets, indicating whether care was provided. The DON stated the nurse should verify care was provided and if a resident refused care, the nurse should document a progress note. During an interview on 06/20/25 at 10:44 A.M., the Administrator stated her expectation was for the CNA to let the nurse know if the resident became combative, and they could not clean their nails. The Administrator stated her expectation was for staff to attempt nail care, communicate with the nurse if they were unable to complete nail care, and if nail care was not able to be completed, they should document the refusal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/25 at 12:39 P.M., Corporate Clinician #20 stated the facility did not have a policy for nail care. Corporate Clinician #20 stated the provision of nail care was standard practice.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, staff interview, and document review, the facility failed to ensure nurse staffing data was posted daily, at the beginning of each shift on the weekends, and contained the resident census as required. This deficient practices had the potential to affect all 90 residents who resided in the facility. The census was 90. Findings included: Review of the facility daily staffing forms, dated 04/01/25 through 06/18/25, revealed the resident census was not documented for each shift, each day. During an observation on 06/18/25 at 8:16 A.M., the posted daily staffing form, dated 06/18/25, located in a cabinet on a wall in a hallway, revealed the posting did not include the resident census. During an observation on 06/19/25 at 11:25 A.M., the daily staffing form for 06/19/25 was not posted in the wall cabinet of the facility. During an interview on 06/19/25 at 10:52 A.M., the Director of Nursing (DON) stated that either she or one of the unit managers completed the daily staffing form and posted the form. The DON stated the daily staffing form was typically completed between 7:00 A.M. and 8:00 A.M. during the weekdays and then posted; however, she had not posted the form for 06/19/25. The DON stated the facility had two shifts, 7:00 A.M. to 7:00 P.M. and 7:00 P.M. to 7:00 A.M. and the daily staffing form, which included the day and night shift totals, was only posted once per day. The DON stated she was not aware the staff posting was required to be posted at the beginning of each shift. The DON stated that the resident census was discussed in a morning meeting but was not included on the daily staffing forms. During a follow-up interview on 06/20/25 at 9:18 A.M., the DON stated that on Fridays, the facility posted projected staffing data for the weekend. Per the DON, there was no one designated to post the daily staffing form on the weekends. During an interview on 06/20/25 at 8:22 A.M., Corporate Clinician #20 stated the facility did not change the daily staffing form each shift during the weekends. During an interview on 06/20/25 at 10:34 A.M., the Administrator stated the nurse staffing data that was posted for the weekends was based on the number of staff who were scheduled. The Administrator stated she reviewed the posting to see that it was present and that the staffing numbers were based on the resident census and acuity. The Administrator stated if someone called off, the on-call nurses knew they would have to work if the shift could not be filled. Per the Administrator, she expected the daily nurse staffing data form to be completed and posted early in the shift. During an interview on 06/20/25 at 8:22 A.M., Corporate Clinician #20 stated the facility did not have a policy related to posting nurse staffing data. Per Corporate Clinician #20, the facility followed federal regulations.

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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. Based on medical record review, staff interview, and facility policy review, the facility failed to hold blood pressure medications when the blood pressure was out of physician prescribed parameters which resulted in a significant medication error. This affected one (#29) of five sampled residents reviewed for unnecessary medications. The census was 90. Findings included: Review of an admission record indicated the facility admitted Resident #29 on 07/26/18. Diagnoses included acute combined systolic and diastolic (congestive) heart failure. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/21/25, revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident had moderate cognitive impairment. Review of Resident #29's care plan report included a focus area initiated 06/29/23 that indicated the resident had cardiac symptoms. Interventions directed staff to administer medications as ordered, monitor for side effects related to anti-hypertensive medication, and monitor the effectiveness of the interventions. Review of Resident #29's order summary report for active orders as of 06/20/25, included an order dated 02/16/24, for Isosorbide Mononitrate (decreases blood pressure) extended release (ER) 60 milligrams (mg), give one tablet by mouth one time daily at 9:00 A.M. for hypertension, with instructions to hold if systolic blood pressure (SBP) was less than 120 millimeters of mercury (mmHg) or heart rate was less than 60 beats per minute (BPM); and an order dated 08/28/24, for Lisinopril (decreases blood pressure)10 mg, give one tablet by mouth two times a day at 9:00 A.M. and 9:00 P.M. for hypertension, with instructions to hold for SBP less than 120 mmHg, heart rate less than 60 BPM. Review of Resident #29's medication administration record (MAR) for the timeframe 04/01/25 through 04/30/25, revealed at 9:00 A.M. on 04/02/25, 04/03/25, 04/10/25, and 04/11/25 Isosorbide Mononitrate ER 60 mg and Lisinopril 10 mg were administered to the resident when their SBP was less than 120 mmHg. Review of Resident #29's MAR for the timeframe 04/01/25 through 04/30/25, revealed Lisinopril 10 mg was administered to the resident at 9:00 P.M. on 04/03/25, 04/05/25, 04/06/25, 04/08/25, 04/10/25, 04/12/25, 04/13/25, 04/15/25, 04/17/25, 04/28/25, and 04/30/25 when the resident's SBP was less than 120 mmHg. Review of Resident #29's MAR for the timeframe 05/01/25 through 05/31/25, revealed at 9:00 A.M. on 05/17/25 and 05/18/25 Isosorbide Mononitrate ER 60 mg and Lisinopril 10 mg were administered to the resident when their SBP was less than 120 mmHg. Review of Resident #29's MAR for the timeframe 05/01/25 through 05/31/25, revealed Lisinopril 10 mg was administered to the resident at 9:00 P.M. on 05/03/25, 05/04/25, 05/05/25, 05/06/25, 05/08/25, 05/09/25, 05/11/25, 05/13/25, 05/14/25, 05/18/25, 05/19/25, 05/28/25, and 05/31/25 when the resident's SBP was less than 120 mmHg (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29's MAR for the timeframe 06/01/25 through 06/30/25, revealed Lisinopril 10 mg was administered to the resident at 9:00 P.M. on 06/05/25 and 06/09/25 when the resident's SBP was less than 120 mmHg. During a telephone interview on 06/20/25 at 5:35 A.M., Licensed Practical Nurse (LPN) #3 stated if a resident had parameters for their medications she would check the resident's vital signs prior to preparing the medications and if the vital signs were out of the established parameters, she would hold the medication and make a note. LPN #3 stated Resident #29's blood pressure medications had an order to hold if the resident's SBP was less than 110 mmHg or their pulse was less than 60 BPM. LPN #3 then checked Resident #29's physician orders and stated the parameters were for 120 mmHg and not 110 mmHg. LPN #3 confirmed she had given the medication when the resident's SBP was out of the parameters on multiple occasions because she thought the parameter was 110 mmHg. LPN #3 stated she should have read the order completely to ensure she was following the physician orders. During a telephone interview on 06/19/25 at 3:49 P.M., Registered Nurse (RN) #2 stated if a resident had parameters for when to hold their medications then she would hold the medication if needed and document on a progress note or put it in the drop-down box on the MAR. RN #2 reviewed the resident's MAR for April 2025 and May 2025 and stated the resident's blood pressure medications should not have been given, but she was typically good about holding the medication and may have signed off that she gave the medication but really held it. RN #2 stated at times she would forget what the parameters were and would need to double check. RN #2 stated she would not have given the medication if Resident #29's blood pressure was 98/53 mmHg (on 04/03/25 at 9:00 P.M.), that it had to be a documentation error, but she was not sure about the other times she documented that she had given it. During an interview on 06/19/25 at 3:25 P.M., LPN #4 stated if the resident's blood pressure was within parameters she would give the blood pressure medication and if not, then she would hold the medication, make a note, notify the physician, then waste the medication. LPN #4 verified that she gave Resident #29 their blood pressure medications when they should have been held on 04/03/25, 05/17/25, and 05/18/25. LPN #4 stated she should have double checked the order to ensure she was giving the medication according to the physician order. During an interview on 06/19/25 at 3:44 P.M., LPN #6 stated if a resident's order had parameters when to hold their blood pressure medications, she would hold the medication until vital signs were obtained and then hold if needed. After review of Resident #29's blood pressures on 04/02/25 and 04/10/25, LPN #6 stated the medication should have been held. LPN #6 stated she was not sure why she did not hold the medication except that most of the resident's hold orders were for 110 mmHg. LPN #6 stated she should have checked and rechecked the order to ensure what the parameters were for that resident. During an interview on 06/20/25 at 9:58 A.M., the Director of Nursing (DON) stated the nurse should be aware of the parameters prior to administering the medications, and if the resident's blood pressure or pulse did not meet the parameters, they should not administer the medication. The DON stated if the medications were held it should be documented on the MAR, but a progress note would not necessarily be written. Per the DON, there were no medication error reports completed for Resident #29. The DON reviewed Resident #29's MARs for April, May, and June 2025 and stated the nurses should not have given the medication on those days the resident's SBP was out of the prescribed parameters. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/25 at 10:17 A.M., the Administrator stated the nurses should read the orders completely, verify and double check everything. The Administrator stated medication should not be given if the resident's vital signs were not in the parameters. After review of Resident #29's MARs, the Administrator stated it was not okay that the nurses administered the medication when the resident's blood pressure was out of the parameters. The Administrator stated that even if they had not given the medication, they still documented that they did, and that was not okay either. During an interview on 06/20/25 at 12:32 P.M., the Medical Director (MD) #30 stated parameters were used for blood pressure medications to keep a resident's blood pressures from going too low, and medications should be held to avoid complications of hypotension, dizziness, and increased risk for falls. MD #30 stated the parameters depended on the resident and the medication. MD #30 stated he was notified on 06/20/25 that the resident's blood pressure medications were not being held according to the parameters. MD #30 stated his expectation was that staff held the medication if it was out of the set parameters, and if the resident was symptomatic, he should be notified. Review of a facility policy titled, Medication Administration, dated 06/11/17, indicated medications will be administered by legally-authorized and trained persons in accordance to applicable State, Local, and Federal laws and consistent with accepted standards of practice. The policy specified to obtain and record any vital signs as necessary prior to medication administration.

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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. Based on observation, staff interview, and review of the facility policy review, the facility failed to ensure hairnets worn by dietary staff in the kitchen restrained all of their hair to ensure food was served in a sanitary manner for the 90 residents who received food from the kitchen. The census was 90. Findings included: During an observation on 06/18/25 at 9:57 A.M., [NAME] #1 was noted to prepare pureed foods. [NAME] #1 wore a hairnet that covered the top part of her hair. [NAME] #1's hair hung down her back and approximately 12 inches of her hair was outside of the hairnet. During an observation on 06/18/25 at 11:10 A.M., [NAME] #1 prepared the lunch meal and the back of her hair remained outside the hairnet. During an observation on 06/18/25 at 11:34 A.M., [NAME] #1 served residents their lunch meal from the steam table and the back of her hair remained outside the hairnet. During an interview on 06/18/25 at 12:30 P.M., [NAME] #1 stated the hairnet should cover her whole head. [NAME] #1 stated she was in a hurry and forgot to properly put on the hairnet. During an interview on 06/18/25 at 3:29 P.M., Regional Registered Dietitian #40 stated her expectation was that hairnets and beard covers should be worn at all times while staff were in the kitchen. During an interview on 06/18/25 at 3:31 P.M., the Dietary Manager (DM) #50 stated her expectation was that staff should always wear a hairnet, and the hairnet should cover all their hair. DM #50 stated it was important to wear a hairnet so that they did not get hair in the residents' food. During an interview on 06/20/25 at 9:37 A.M., the Director of Nursing (DON) stated her expectation was that kitchen staff wore hairnets that covered their hair. During an interview on 06/20/25 at 9:43 A.M., the Administrator stated her expectation was that staff always wore hairnets in the kitchen. The Administrator stated everyone who went into the kitchen should wear a hairnet, and the hairnet should cover all their hair. Review of a facility policy titled, Infection Control - Dietary/Food Handling, revised 05/2015, indicated hairnets or caps must be worn to effectively keep hair from contacting exposed food, clean equipment, utensils and linens.