STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366364	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Triple Creek Retirement Community	11230 Pippin Road Cincinnati, OH 45231

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and policy review, the facility failed to ensure proper personal protective equipment (PPE) was worn while providing care and services for a resident on Enhanced Barrier Precautions (EBP). This affected one (Resident #29) of three residents reviewed for infection control. The facility census was 45. Review of the medical record revealed Resident #29 was admitted to the facility on [DATE] with diagnoses including toxic encephalopathy, Parkinson's disease, and gastrostomy status. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #29 was moderately cognitively impaired, was dependent on staff for toileting and lower body dressing and occasionally incontinent of urine and frequently incontinent of bowels. Review of the physician orders revealed Resident #29 had an active order dated 02/24/26 for staff to use EBP during high-contact care activities. Observations on 03/24/26 from 10:15 A.M. to 10:28 A.M., revealed Certified Nursing Assistant (CAN) #09 was in Resident #29's room with the door shut. CNA #09 was observed exiting and reentering the room without a gown on several occasions throughout the observation. Resident #29 had a sign on his door stating that he was on EBP and there was not a supply of PPE near his room. During an interview on 03/24/26 at 10:29 A.M. with Licensed Practical Nurse #17 revealed that CNA #09 was assisting Resident #29 with toileting and getting the resident dressed. Observation on 03/24/26 at 10:31 A.M. revealed CTNA #09 in Resident #29's room changing his bed sheets without a gown. A clear trash bag was observed in the room with discarded products. There were no gowns observed in the trash bag. During an interview on 03/24/26 at 10:32 A.M., CNA #09 verified that she was assisting Resident #29 with perineal care, toileting, and getting dressed. CNA #09 verified that Resident #29 was on EBP, there was not a supply of PPE near his room and that she did not wear a gown while providing personal care. Review of the active care plan revealed Resident #29 required EBP during high-contact care related to the presence of a feeding tube. Interventions included utilizing gowns and gloves per EBP policy during high contact activity of daily living (ADL) care (e.g. dressing, showering/bathing, hygiene, and toileting/changing briefs) and during linen changes. Review of the facility policy titled Enhanced Barrier Precautions (EBP) Standard Operating Procedure dated 12/3/25, revealed that at minimum, staff shall wear gloves and gowns during high contact care activities including ADL care, toileting, and showers.

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