

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2025
NAME OF PROVIDER OR SUPPLIER  Covenant Village of Green Township		STREET ADDRESS, CITY, STATE, ZIP CODE  3210 West Fork 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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interviews, interview with staff at oral surgeon's office, review of the weather history for Cincinnati, and record review, the facility failed to ensure residents were treated with respect and dignity. This affected one (#12) of two residents reviewed for dignity and respect. The facility census was 102. Findings include:Record review revealed Resident #12 was admitted to facility on 11/09/24. Diagnoses included zygomatic fracture (a break in the cheek bone) and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 required maximum assistance with toileting and dressing and utilized a wheelchair for mobility. Interview with Oral Surgery Office Staff (OSOS) #600 on 09/29/25 at 11:05 A.M. revealed Resident #12 came to the oral surgery clinic at Medical Center (MC) #500 on 01/08/25 for a morning appointment related to her zygomatic fracture. The oral surgery's office (OSO) was called by the MC #500's lobby desk reporting Resident #12 had been dropped off by transport company leaving her unattended in the lobby. Resident #12 was unsure of why she was there and where she was supposed to go. OSOS #600 stated she went to the lobby where she found Resident #12 sitting unaccompanied in a wheelchair, dressed only with a hospital gown and socks on a cold winter day. OSOS #600 revealed Resident #12 brought no paperwork from the facility and was not sure why she was being seen. OSOS #600 transported the resident to OSO. Interview on 11/25/25 at 1:14 P.M. with Facility Nursing Supervisor # 67 revealed she was not aware Resident #12 was out of the building for an appointment on 01/08/25, until the OSO called requesting information about who was supposed to accompany Resident #12 to her appointment. The caller also requested updated medical records be faxed to OSO, as well expressing her concern about how Resident #12 was dressed. Facility Nursing Supervisor #67 explained she would have to investigate the situation before she could answer the questions. Facility Nursing Supervisor #67 went to the facility floor staff who confirmed Resident #12 was out of the building at the OSO. Staff verified Resident #12 was sent without an escort and was dressed in a hospital gown as family had not brought her any clothing. Nursing Supervisor #67 assumed Resident #12 was sent out with blankets but did not observe the resident prior to leaving the building. Interview on 11/25/25 at 11:17 A.M. with Licensed Practical Nurse (LPN) #65 who was assigned to Resident #12 on 01/08/25 revealed caregiving staff were unaware Resident #12 had an early morning appointment. Staff caring for Resident #12 had to work quickly to get Resident #12 ready and out to transport van. LPN #65 revealed Resident #12 did not have any clothing of her own, so was sent dressed in two hospital gowns, one in front and one in back as well as socks. LPN #65 revealed she did not see Resident #12 getting on the van so was unsure what she was sent with to keep her warm. Interview with Housekeeping Director (HD) #61 on 11/25/25 at 4:30 P.M. revealed facility maintains a lost and found area in the laundry department which staff can use for residents who were going out and do not have appropriate clothing. HD #61 revealed she also has a closet of clothes in her office that have been donated just for that purpose for residents without clothes of their own. HD #61 revealed staff have been notified about the closet they can use for residents without clothes. Review of the weather history for Cincinnati on 01/08/25 revealed the temperature was a high of 25 degrees Fahrenheit (F) and a low of 18 degrees F. This deficiency represents non-compliance investigated under Complaint Number OH00161459 (1343852) and Complaint Number OH00161661 (1343853).</p>		