| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366399 | A. Building<br>B. Wing | 04/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Covenant Village Care Center | 3210 West Fork Road<br>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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, the facility failed to ensure a safe discharge. This affected one Resident #111 of three residents reviewed for discharge. The facility census was 104.Findings include:Review of the medical record revealed Resident #111 was admitted to the facility on [DATE] and discharged on 01/02/26. Diagnoses included atrial fibrillation, depression, mental disorder, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and essential hypertension.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #111 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) of eight, required set up awsistance for eating, substantial assistance with toileting, substantial assistance with bathing, and set up assistance for personal hygiene.Review of the Letter of Guardianship dated 12/02/25 revealed Resident #111 incompetent for an indefinite time period.Review of the Discharge summary dated [DATE] revealed Resident #111 discharged to own home, son will provide transportation, functional impairments listed as decision making, discharge paperwork reviewed with patient.Review of the social service note dated 01/02/26 at 10:44 A.M.for Resident #111 revealed call placed to resident daughter to follow up that she received the notification that the appeal was lost, left name and number to return call if she had any questions. Review of the social service progress note dated 01/02/2026 at 12:11 P.M. revealed Resident #111 to discharge home on [DATE] with Home Health Care (HHC), son will be providing transportation, no further discharge needs identified at this time.Review of the social service progress note for Resident #111 dated 01/02/2026 at 2:41 P.M. revealed resident discharged home with brother at this time. Discharge instructions reviewed with resident. All medications sent with resident. Paperwork signed.Review of the social service progress note for Resident #111 dated 01/02/2026 at 3:09 P.M. revealed spoke with resident regarding discharge plan and he was adamant he was returning home and would not stay in a Long Term Facility (LTC) facility or transfer to another LTC facility. Resident, per discussion with resident, does not have evidence the resident is incompetent to make his decisions. Resident verbalized the risk associated with living alone. Recommendation for alternative placement should be discussed when/if resident needs placement and discussed from family and assisted in that process when appropriate.Review of the HHC notification dated 01/02/26 for Resident #111 revealed HHC was planned and accepted on 01/02/26. Interview on 03/31/26 at 10:47 A.M. with Social Service Assistant (SSA) #6 and the Administrator revealed referral for HHC for Resident #111 was sent on day of discharge, Resident #111 made decision last minute to go home. SSA #6 stated the referral to HHC usually happens prior to the day of discharge. SS #6 confirmed Resident #111's Guardian did not give approval for the resident to discharge home and resident set up his own transportation, he said he was going to call his brother. Review of the policy titled, Transfer and Discharge, dated 04/28/25, revealed orientation for transfer or discharge will be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand.This deficiency represents non-compliance investigated under Complaint Number 2706399. |

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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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, the facility failed to have a baseline care plan that included pain management and hearing loss. This affected one, (Resident #2) of six residents reviewed for the baseline care plan. The facility census was 104.Findings include:Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included discoid lupus erythematosus, depression, polyarthritis, cardiac arrhythmia, cervical disc disorder, other displaced fracture of upper end of left humerus and rheumatic mitral stenosis.Review of the most recent Minimum Data Set (MDS) 3.0 assessment still in progress dated 02/09/26 revealed Resident #2 was cognitively intact. Review of the baseline care plan dated 03/27/26 revealed Resident #2's pain was not assessed or added to the baseline care plan and hearing loss with a hearing aide was not assessed or added to the baseline care plan.Review of the medical record revealed Resident #2 revealed a hospital discharge order dated 03/19/26 for Oxycodone (opioid) immediate release five milligrams (mg) every four hours as needed.Review of the facility medical record revealed Resident #2 had physician orders dated 03/27/26 at 2:45 P.M. for Oxycodone oral tablet five mg give one tablet every six hours as needed for pain related to other displaced fracture of upper end of left humerus.Interview with Resident #2 on 03/30/26 at 10:57 A.M. revealed the resident had excruciating pain and could not get the Oxycodone, as the facility was not able to give to her for 36 hours. Further interview with Resident #2 revealed the resident had hearing loss and wore hearing aids.Interview on 04/02/26 at 10:32 A.M. with the MDS coordinator #42 confirmed Resident #2's baseline care plan did not have pain or hearing loss those should have been included.Review of the policy titled, Care Plan, dated 12/2019 revealed baseline care plan must include the minimum healthcare information necessary to properly care for a resident. This deficiency represents non-compliance investigated under Complaint Number 2700708. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, policy review and record reviews, the facility failed to ensure residents' activity needs were assessed regularly and addressed in the care plans. This affected two Residents #40 and Resident #54 of three residents reviewed for care plans. The facility census was 104.Findings include:1. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE]. Diagnoses included dizziness, chronic embolism and thrombosis of unspecified vein, dysphagia, alzheimer's disease, and anxiety disorder.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #40 had severe cognitive impairment, was dependent with eating, dependent with bathing, and dependent with personal hygiene. Review of the Care Area Assessment Summary (CAA) dated 11/11/25, for Resident #40 revealed activities was triggered for a care area and care planning decision. Review of the care plan for Resident #40 revealed no goals or interventions for activities. Review of Resident #40 medical record revealed a completed activity assessment dated [DATE]. 2. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE]. Diagnoses included huntington's disease, essential hypertension, ataxia, corticobasal degeneration, cognitive communication deficit, and dysphagia.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #54 severe cognitive impairment, partial assistance with eating, substantial assistance with toileting, substantial assistance with bathing, and partial assistance with personal hygiene. Review of the Care Area Assessment Summary (CAA) dated 12/16/25, for Resident #54 revealed activities was triggered for a care area and care planning decision. Review of the care plan for Resident #54 revealed no goals or interventions for activities. Review of Resident #54 medical record revealed a completed activity assessment dated [DATE].Interview on 04/06/26 at 1:15 P.M. with the Activities Director (AD) #45 revealed there are no documented ongoing activity preferences or assessments for Resident #40 and Resident #54. Interview on 04/07/26 at 1:35 P.M. with the Director of Nursing (DON) confirmed that the Resident #40 and Resident #54 did not have activities listed in their care plans. The DON also confirmed that there was no quarterly assessments done for activities for Resident #40 and Resident #54 and the only assessments are listed above.Review of the policy titled, Care Plan Policy, dated 12/2019, revealed the comprehensive care plan must be person centered, have measurable goals with appropriate interventions to assist with obtaining those goals and contain all necessary information to allow the resident to receive care while maintaining their highest practicable well-being.Review of the policy titled, Activities, dated 08/2025, revealed comprehensive activity evaluations are completed upon admission, routinely, and as needed with a change in condition that affects activity participation. Comprehensive activity evaluations are used to develop and revise activity care plans that meet the individual choices, hobbies, and cultural preferences and interests of the residents. Activity evaluations and care plans should identify if a resident is capable of pursuing activities independently, or if supervision and assistance are needed. This deficiency represents non-compliance investigated under Complaint Number 2700708. |

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| | 366399 | A. Building<br>B. Wing | 04/07/2026 |

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| Covenant Village Care Center | 3210 West Fork Road<br>Cincinnati, OH 45211 |

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|---|---|
| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure pain medications were available for a resident. This affected one, (Resident #2) of six residents reviewed for medications. The facility census was 104. Findings include:Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included discoid lupus erythematosus, depression, polyarthritis, cardiac arrhythmia, cervical disc disorder, other displaced fracture of upper end of left humerus and rheumatic mitral stenosis.Review of the most recent Minimum Data Set (MDS) 3.0 assessment still in progress dated 02/09/26 revealed Resident #2 was cognitively intact. Review of the medical record revealed Resident #2's hospital discharge orders dated 03/19/26 revealed Oxycodone (opioid) immediate release five milligrams (mg) every four hours as needed.Review of the medical record revealed Resident #2 had physician orders dated 03/27/26 at 2:45 P.M. revealed Oxycodone oral tablet five mg give one tablet every six hours as needed for pain related to other displaced fracture of upper end of left humerus.Review of the Medication Administration Record (MAR) for Resident #2 revealed Oxycodone was first given on 03/29/26 at 8:55 A.M with a pain level of nine.Interview on 03/30/26 at 10:57 A.M. with Resident #2 stated she had excruciating pain when she admitted and could not get the Oxycodone, and the facility was not able to give to her for 36 hours.Interview on 03/30/26 at 12:59 P.M. with the Director of Nursing (DON) revealed Resident #2 arrived with an order for Oxycodone from the hospital, the perscription was sent to specialty pharmacy, with no signature. The DON confirmed Resident #2 did not have the available ordered Oxycodone from 03/27/26 to 03/29/26. Review of the policy titled, Pain Assessment and Management, dated 08/2025, revealed review the medication administration record to determine how often the individual requests and receives as needed pain medication, and to what extent the administered medications relieve the resident's pain.This deficiency represents non-compliance investigated under Complaint Number 2788877 and 2722512. |

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|---|---|
| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a sanitary environment. This affected one, (Resident #54) of three residents reviewed for a sanitary environment. The facility census was 104.Findings include:Review of the medical record revealed Resident #54 was admitted to the facility on [DATE]. Diagnoses included huntington's disease, essential hypertension, ataxia, corticobasal degeneration, cognitive communication deficit, and dysphagia.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #54 has severe cognitive impairment, required partial assistance with eating, substantial assistance with toileting, substantial assistance with bathing, and partial assistance with personal hygiene.Observation and interview on 04/06/26 at 9:17 A.M. in Resident # 54 room with the Maintenance Director (MD) #82 and the Administrator revealed the floor was covered with small white spots, appearing to be paint chips stuck to floor. Continued observation and confirmation with the MD #82 and the Administrator revealed the wall next to the footboard had paint worn off about six inches by 12 inches, the wall next to the top bed rail had paint worn and black scuff marks measuring about 12 inches by 18 inches, and the wall next to the headboard has paint worn off measuring about one inch by eight inches. Continued interview at the same time with the MD #82 confirmed the walls and floor should be fixed prior to getting to this point.Review of the policy titled, Environmental Services Inspection, dated 12/2025, revealed it is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis. The Director of Environmental Services will perform random and/or routine inspections. All opportunities will be corrected immediately by environmental services personnel.This deficiency represents non-compliance investigated under Complaint Number 2970102 and Complaint Number 2722512. |