| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366427 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Liberty Nursing Center of Colerain Inc | 8440 Livingston Road<br>Cincinnati, OH 45247 |

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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on medical record review, review of facility communication with outside entities, staff interview, and review of the facility policy, the facility failed to ensure confidentiality of residents' private health information. This affected one (Resident #82) of three residents reviewed for confidentiality. The facility census was 67 residents.Findings include: Review of the medical record for Resident #82 revealed an admission date of 04/29/21 with diagnoses including end stage renal disease, type two diabetes mellitus, and congestive heart failure and a discharge date of 05/14/25. Review of the Minimum Data Set (MDS) assessment Resident #82 revealed the resident had moderately impaired cognition and required supervision with activities of daily living (ADLs.) Review of a written facility communication regarding Resident #82 dated 06/12/25 to the Better Business Bureau (BBB) (a private, non-profit organization with no governmental authority) revealed the letter contained Resident #82's name, diagnoses, weights, prescribed medications, and additional confidential information. Interview on 08/21/25 at 1:28 P.M. with the Administrator confirmed the facility received communication via the mail from the BBB regarding a complaint about the facility made by Resident #82's family. The Administrator stated he spoke with the BBB representative who said the facility did not have to respond to the complaint. The Administrator confirmed he consulted the corporate office and was given direction to respond to the BBB regarding the complaint made by Resident #82's family. The Administrator stated he emailed the response to the BBB dated 06/12/25 and verified the response contained private health information about Resident #82. Review of the facility policy titled Confidentiality of Information and Personal Privacy dated October 2017 revealed the facility would safeguard the personal privacy of all resident personal and medical records and access to resident personal and medical records would be limited to authorized staff and business associates.This deficiency represents noncompliance investigated under Complaint OH00164348 (iQIES 1393019) |

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 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 medical record review, staff interview, and review of the facility policy, the facility failed to develop individualized comprehensive resident care plans. This affected one (Resident #80) of 11 residents reviewed for care plans. The facility census was 67 residents.Findings include:Review of the medical record for Resident #80 revealed an admission date of 12/16/22 with diagnoses including end stage renal disease, diabetes mellitus type two, and chronic obstructive pulmonary disease and a discharge date of 08/02/25. Review of hospital records for Resident #80 dated 06/06/25 to 06/08/25 revealed an x-ray of the resident's left foot showed a fracture to the resident's left ankle. Orthopedics evaluated Resident #80, splinted the resident's left lower extremity, and scheduled the resident for follow-up with an orthopedist for 06/10/25. Review of physician's orders for Resident #80 dated 06/08/25 to 08/02/25 revealed there were no orders for care of the left foot nor for care of a splint to the left foot. Review of the care plan for Resident #80 revealed it did not include a care plan for the resident's left ankle fracture, a splint to the left foot, and care to be provided to the left foot. Review of Minimum Data Set (MDS) assessment for Resident #80 dated 07/16/25 revealed the resident was cognitively intact and required assistance with mobility and toileting. Interview on 08/19/25 at 3:05 P.M. with the Assistant Director of Nursing (ADON) confirmed Resident #80 had a splint on her left lower extremity upon return from the hospital on [DATE] but there were no orders or care plan in the resident's medical record that reflected the presence or care of the splint. Interview on 08/25/25 at 1:40 P.M. with Registered Nurse (RN) #300 confirmed Resident #80's care plan did not reflect the presence of the resident's left ankle fracture, the splint to the left foot, and/or care for the fracture. Review of the facility policy titled Medical Device Related Pressure Injury dated January 2018 revealed the use of medical devices should be reflected on the care plan, and if a device is not to be removed, then the orders should reflect that. This deficiency represents noncompliance investigated under Complaint Number OH00164348 (iQIES 1393019.) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on medical record review and staff interview, the facility failed to ensure dependent residents received appropriate bathing assistance. This affected one (Resident #85) of three residents reviewed for bathing assistance. The facility census was 67 residents. Findings include: Review of the medical record for Resident #85 revealed an admission date of 02/21/25 with diagnoses including an open wound of the abdominal wall with a discharge date of 05/22/25.Review of the Minimum Data Set (MDS) assessment for Resident #85 dated 03/14/25 revealed the resident had moderate cognitive impairment and required assistance with bathing, toileting, and dressing. Review of the care plan for Resident #85 dated 03/21/25 revealed the resident required assistance by staff with bathing/showers per schedule and as necessary and to provide a sponge bath when a full bath or shower could not be tolerated. Review of shower sheets for Resident #85 from 04/01/25 to 05/22/25 revealed the resident had four recorded baths on the following dates: 04/06/25, 04/12/25, 05/01/25, and 05/22/25. Interview on 08/26/25 at 3:00 P.M. with the Assistant Director of Nursing (ADON) confirmed there were only four shower/bath sheets completed for Resident #85. The ADON confirmed the expectation was residents would be offered at least two baths/showers per week as scheduled, which should have been 15 showers/baths during the reviewed time period.This deficiency represents noncompliance investigated under Complaint Number 2576092 and Complaint Number OH00166049 (iQIES 1393018) and Complaint Number OH00164348 (iQIES 1393019) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to implement physician orders for fracture and splint care and failed to implement orders for wound care. This affected two Residents (#80, #82) of 11 residents reviewed for quality of care. The facility census was 67 residents.Findings include: 1.Review of the medical record for Resident #80 revealed an admission date of 12/16/22 with diagnoses including end stage renal disease, diabetes mellitus type two, and chronic obstructive pulmonary disease and a discharge date of 08/02/25<br><br>Review of hospital records for Resident #80 dated 06/06/25 to 06/08/25 revealed an x-ray of the resident’s left foot showed a fracture to the resident’s left ankle. Orthopedics evaluated Resident #80, splinted the resident’s left lower extremity, and scheduled the resident for follow-up with an orthopedist for 06/10/25.<br><br>Review of physician’s orders for Resident #80 dated 06/08/25 to 08/02/25 revealed there were no orders for care of the left foot nor for care of a splint to the left foot.<br><br>Review of the care plan for Resident #80 revealed it did not include a care plan for the resident’s left ankle fracture, a splint to the left foot, and care to be provided to the left foot.<br><br>Review of Minimum Data Set (MDS) assessment for Resident #80 dated 07/16/25 revealed the resident was cognitively intact and required assistance with mobility and toileting.<br><br>Interview on 08/19/25 at 3:05 P.M. with the Assistant Director of Nursing (ADON) verified Resident #80 returned from the hospital with a splint on her left lower extremity and no orders were present in her records at the facility to reflect the presence or care of the splint or leg.<br><br>Interview on 08/25/25 at 1:40 P.M. with Registered Nurse (RN) #300 verified Resident #80’s physician orders did not include orders for a non-removable left leg splint.<br><br>2. Review of the medical record for Resident #82 revealed an admission date of 04/29/21 with diagnoses including end-stage renal disease, cerebral infarction, and type two diabetes mellitus and discharge date of 05/14/25.<br><br>Review of the MDS assessment for Resident #82 dated 03/20/25 revealed the resident had moderately impaired cognition and required supervision with activities of daily living (ADLs.)<br><br>Review of a hospital after visit summary for Resident #82 dated 03/26/25 revealed the resident visited the hospital for a wound check and was diagnosed with an ulcer to the right leg. Instructions included to apply a wet-to-dry dressing to the right lower leg and change every eight hours.<br><br>Review of a nurse progress note for Resident #82 dated 03/26/25 revealed the resident returned from the hospital and the daughter informed staff the hospital wanted a wet-to-dry dressing changed every eight hours. The nurse documented there was handwriting on the after-visit summary, but no signature. The note did not include documentation of contact with the physician or hospital for order clarification. Review of the readmission physician’s orders for Resident #82 revealed they did not include orders for wound care for the ulcer to the right lower leg.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a nurse progress note for Resident #82 dated 03/27/25 revealed the resident went outside of the facility for a wound consult and received orders for wound care daily to the ulcer on the right lower leg which included the following: clean wound with normal saline, pack gauze coated with Medihoney into wound, cover with ABD pad, tape in place.<br><br>Review of the physician’s orders for Resident #82 revealed the order from the wound clinic for the treatment to the resident’s right lower leg ulcer were not implemented until 03/29/25 at 7:00 P.M.<br><br>Interview on 08/26/25 at 12:18 P.M. with Licensed Practical Nurse (LPN) #373 verified Resident #82 returned from the hospital on [DATE] with a non-pressure wound to the right lower leg. The orders in the hospital after visit summary for a wet to dry dressing were not implement. LPN #373 confirmed Resident #82 returned from a wound clinic on 03/27/25 with updated orders for wound care to the right lower leg ulcer which were not implemented until 03/29/25.<br><br>This deficiency represents noncompliance investigated under Complaint Number 2576092 and Complaint Number OH00166049 (iQIES 1393018) and Complaint Number OH00165759 (iQIES 1393020) and Complaint Number OH00164258 (iQIES 1393015) and Complaint Number OH00164348 (iQIES 1393019) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure falls were investigated in a timely manner. This affected two (Residents #82 and #84) of four residents reviewed for falls. The facility census was 67 residents.Findings include:1.Review of the medical record for Resident #84 revealed an admission date of 02/28/25 with diagnoses including convulsions, dementia, and bipolar disorder and a discharge date of 06/04/25.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #84 dated 04/20/25 revealed the resident had moderate cognitive impairment.<br><br>Review of the document titled unwitnessed fall for Resident #84 dated 06/01/25 at 10:20 P.M. revealed the resident was found on the floor next to the bed and was unable to give a description of how she fell. The resident was taken to a local hospital for evaluation.<br><br>Review of the medical record for Resident #84 revealed it did not include a fall investigation for the resident’s fall on 06/01/25.<br><br>Interview on 08/19/25 at 2:39 P.M. with the Assistant Director of Nursing (ADON) confirmed the facility had no record of an interdisciplinary team (IDT) fall investigation regarding Resident #84’s fall on 06/01/25. The ADON verified that the facility should complete an investigation including a root cause analysis of each resident fall and should determine actions to prevent recurrence.<br><br>2. Review of the medical record for Resident #82 revealed an admission date of 04/29/21 with diagnoses including end-stage renal disease, cerebral infarction, and type 2 diabetes mellitus and a discharge date of 05/14/25.<br><br>Review of the fall risk assessment for Resident #82 dated 02/10/25 revealed the resident was at moderate risk for falls.<br><br>Review of the MDS assessment for Resident #82 dated 03/20/25 revealed the resident had moderately impaired cognition and required supervision with activities of daily living (ADLs).<br><br>Review of a progress note for Resident #82 dated 04/08/25 revealed the resident was found on the floor in a sitting position. The resident stated she was trying to go to the restroom and fell down. The resident had no injuries. Review of an the fall investigation note for Resident #82 dated revealed the IDT met to discuss the resident’s fall on 04/08/25. The resident was noted attempting to go to the restroom and did not have any shoes or socks on at the time. A new intervention was implemented for non-skid socks during time of transfers.Review of a progress note for Resident #82 dated 04/15/25 revealed while waiting on transportation the resident went back to her room and fell sustaining a laceration and knot on her scalp. The nurse assessed Resident #82 and the resident was sent to the hospital via ambulance.<br><br>Review of the medical record for Resident #82 revealed it did not include a fall investigation for the resident’s fall on 04/15/25.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 08/26/25 at 3:50 P.M. with Licensed Practical Nurse (LPN) #373 confirmed the facility had not completed an investigation of Resident 82’s fall on 04/08/25 until 04/14/25 and the facility had not completed a fall investigation for the resident’s fall on 04/15/25. Review of the facility policy titled Falls-Clinical Protocol dated March 2018 revealed following a fall, the staff and the practitioner should begin to try and identify possible causes within 24 hours of the fall and, based on the assessment of the fall, staff and the physician will identify pertinent investigations to try to prevent subsequent falls and address the risks of clinically significant consequences of falling.<br><br>This deficiency represents noncompliance investigated under Complaint Number OH00163748 (iQIES 1393014) and Complaint Number 2576092 and Complaint Number 2566204 and Complaint Number OH00166770 (iQIES 1393017) and Complaint Number OH00166404 (iQIES 1393016) and Complaint Number OH00165759 (iQIES 1393020) and Complaint Number OH00164258 (iQIES 1393015) and Complaint Number OH00164348 (iQIES 1393019). |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on staff interview and review of staff job descriptions, the facility failed to designate a dedicated Registered Nurse (RN) to serve as the full time Director of Nursing (DON.) This had the potential to affect all of the residents residing in the facility. The facility census was 67 residents.Findings include: Interview on 08/19/25 at 9:30 A.M. with the Administrator confirmed the Director of Nursing (DON) was on medical leave and had not been working in the facility since 07/22/25. The Administrator confirmed the facility designated Registered Nurse (RN)#300 who was the facility's sole Minimum Data Set (MDS) nurse to also serve as the interim DON. Interview at 08/21/25 at 9:16 A.M. with Social Services Director (SSD) #339 confirmed RN #300 was the facility's full time MDS Nurse who was also responsible for maintaining the care plans for all of the residents in the facility. Interview on 08/21/25 08/21/25 at 12:42 P.M. with the Assistant Director of Nursing (ADON) stated the DON had a medical emergency and had been unable to work since 07/22/5.The ADON verified the facility had designated RN #300 to serve as the acting DON while still performing full-time MDS duties. The ADON verified RN #300 was the facility's only MDS nurse.Interview on 08/25/25 at 1:40 P. M. with RN #300 confirmed she was the facility's only MDS Nurse. RN #300 verified the facility had designated her to be the acting DON during the DON's absence, but she already had a full-time position with the facility as the MDS nurse. Review of the job description for the DON revealed the DON's primary purpose was planning, organizing, developing, and directing the day-to-day functions of the nursing department in accordance with rules, regulations, and guidelines that govern the long-term care facility and ensuring that all nursing personnel are following their respective job descriptions. |