

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Liberty Nursing Center of Colerain Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 8440 Livingston Road 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 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 medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to provide proper nail care. This affected two (Residents #41 and #56) of three residents reviewed for activities of daily living (ADL) care. The facility census was 59 residents. Findings include: 1. Review of the medical record for Resident #41 revealed an admission date of 03/28/25 with diagnoses including femur fracture, atrial fibrillation, depression, dementia, and cecum cancer. Review of the Minimum Data Set (MDS) assessment for Resident #41 dated 04/27/26 revealed the resident had intact cognition and required maximum staff assistance with personal hygiene. Observation on 07/22/26 at 10:55 A.M. revealed Resident #41's fingernails were excessively long, extending approximately one-half inch beyond the tip of the resident's finger, with chipped nail polish on some nails and dirt under all of the resident's nails. Interview on 07/22/26 at 10:56 A.M. with Resident #41 confirmed her fingernails were too long and had jagged edges. Resident #41 stated staff gave her showers twice weekly but no one had offered her nail care. Interview on 07/23/26 at 10:55 A.M. with Licensed Practical Nurse (LPN) #261 verified Resident #41's nails were long and dirty and appeared as if they hadn't been trimmed in some time. 2. Review of the medical record review for Resident #56 revealed an admission date of 04/08/26 with diagnoses including cerebral infarction, hemiplegia and hemiparesis, and rectal cancer. Review of the MDS assessment for Resident #56 dated 04/21/26 revealed the resident had moderate cognitive impairment and required staff assistance with ADLs. Observation on 07/22/26 at 3:22 P.M. of Resident #56 revealed the resident's fingernails were long, extending approximately one-half inch beyond the top of the resident's finger. Interview on 07/22/26 at 3:23 P.M. of Resident #56 verified his nails were too long and no one had offered to trim them. Interview on 07/22/26 at 3:36 P.M. with Certified Nursing Assistant (CNA) #219 confirmed Resident #56's fingernails were too long and needed attention. Review of the facility policy titled Care of Fingernails/Toenails undated revealed nail care included daily cleaning and regular trimming of nails. This deficiency represents noncompliance investigated under Complaint Number3072675.		

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on medical record review, observation, staff interview, and review of facility documents and policy, the facility failed to provide or arrange for proper foot care. This affected one (Resident #15) of three residents reviewed for foot care. The facility census was 59 residents. Findings include: Review of medical record for Resident #15 revealed an admission date of 03/21/26 with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, and congestive heart failure (CHF.) Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 07/02/26 revealed the resident had moderate cognitive impairment and required staff assistance with personal hygiene. Observation on 07/23/26 at 8:13 A.M. revealed the toenails to Resident #15's great toes were both overgrown. Interview on 07/23/26 at 8:14 A.M. with Licensed Practical Nurse (LPN) #115 verified both of Resident #15's feet had overgrown toenails on both great toes and the nails needed to be trimmed. LPN #115 stated he thought Resident #15 was seen by podiatry who would cut her toenails. Interview on 07/22/26 at 3:27 P.M. with Social Service Designee (SSD) #263 stated Resident #15's family had opted not to enroll the resident to be seen by the facility podiatrist during the resident's admission care conference. Interview on 07/23/26 at 12:39 P.M. with Lead Certified Nursing Assistant (CNA) #219 confirmed she thought Resident #15 had her foot care done by the consulting podiatrist. CNA #219 stated if a resident was not on the list to be seen by podiatry the facility nursing staff should take care of the resident's feet and cut her toenails as needed. Interview on 07/23/26 at 3:40 P.M. with the Director of Nursing (DON) confirmed nursing staff were ultimately responsible for foot care and facility nurses should be doing regular skin checks which would involve observing residents' feet. Nursing should address any issues that are discovered. Review of the facility's ancillary services list revealed Resident #15 was not on the list to see podiatry. Review of the facility policy titled Care of Fingernails and Toenails undated revealed nailcare should occur daily with cleaning and regular trimming. CNAs were not to trim nails of diabetic residents or resident with circulatory problems. Any changes in color of skin around nail bed, blue colored nails, cracking of the skin between the toes and any swelling or bleeding should be reported to the nurse. This deficiency represents noncompliance investigated under Complaint Number 3072675.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on medical record review, observation, and staff interview, the facility failed to provide appropriately textured food which resident was able to tolerate. This affected one resident (Resident #15) of three residents reviewed for specialized diets. The facility census was 59 residents. Findings include: Review of the medical record for Resident #15 revealed an admission date of 03/21/26 with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, and congestive heart failure (CHF.) Review of the admission orders for Resident #15 revealed the resident had an order for a regular diet. Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 07/02/26 revealed the resident had moderate cognitive impairment and had no natural teeth. Observation on 07/22/26 at 1:18 P.M. revealed resident was trying to eat a pork chop which had been cut into one-inch squares. Resident #15 placed a piece of the pork into her mouth and chewed for several minutes before spitting out the piece of pork into her napkin. Interview on 07/22/26 at 1:20 P.M. with Resident #15 confirmed she had no natural teeth and meats were impossible for her to chew. Interview on 07/23/26 at 1:23 P.M. with Certified Nursing Assistant (CNA) #297 confirmed Resident #15 had no natural teeth and was unable to chew meats. Interview on 07/22/26 at 1:29 P.M. with Licensed Practical Nurse (LPN) #261 verified she was unaware Resident #15 had no teeth nor was she aware the resident was served meat which the resident was unable to eat. LPN #261 stated therapy would evaluate residents with no teeth to determine what type of diet was most appropriate. Interview on 07/23/26 at 8:44 A.M. with Speech Therapist (ST) #287 confirmed therapy had not seen Resident #15 to determine if the resident was on the proper diet. ST #287 stated therapy had not received a referral for Resident #15 to be evaluated. Interview on 07/23/26 at 12:47 P.M. with the Director of Nursing (DON) confirmed Resident #15 had been admitted with orders for a regular diet. The DON stated the facility was going to get Resident #15's diet order changed to regular diet with minced meat. Interview on 07/23/26 with Dietitian #298 confirmed she was unaware Resident #15 was having issues with chewing meat. Dietitian #298 stated she relied on nursing staff to alert her if there was an issue with a resident's diet, and residents without natural teeth should be evaluated by speech therapy for proper diet. This deficiency represents noncompliance investigated under Complaint Number 3072675.		