STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366467	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Cincinnati	1400 Mallard Cove Drive Cincinnati, OH 45246

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on medical record review, observation, staff interview, manufacturer directions and policy review, the facility failed to ensure medications were administered as ordered. There were four medication errors out of 26 opportunities for error which resulted in a 15.38 percent medication error rate. This affected four (#17, #18, #19, #20) of five residents reviewed for medication administration. The facility census was 34.Findings Include:1.Review of the medical record for Resident #19 revealed an admission date of 10/29/25. Diagnoses included metabolic encephalopathy and rhabdomyolysis.Review of the physician orders for Resident #19 revealed an order for a chewable 81milligram (mg) Aspirin tablet with a start date of 10/30/25.Observation on 11/05/25 at 7:39 A.M. Licensed Practical Nurse (LPN) #111 prepared and administered Resident #19 two Fluconazole (antifungal) 200 mg tablets, Gabapentin (nerve pain) 600 mg tablet and an 81 mg Enteric Coated (EC) Aspirin.Interview on 11/05/25 at 7:51 A.M. LPN #111 verified she had administered an EC aspirin and acknowledged the order was for a chewable tablet.2.Review of the medical record for Resident #20 revealed an admission date of 10/22/25. Diagnoses included intestinal obstruction, hypertension and peripheral vascular disease.Review of the physician orders for Resident #20 revealed an order for Folic Acid 1 mg tablet daily with a start date of 10/30/25.Observation and interview on 11/05/25 at 7:46 A.M. LPN #111 prepared and administered Resident #20 one Vitamin D (supplement) 5000 international unit (iu) capsule, one 30 mg coenzyme Q10 (supplement) capsule, Florenex (probiotic) capsule, Lidoderm (pain) five percent (%) patch, Vitamin B12 (supplement) 1000 microgram (mcg) tablet, Miralax (laxative) 17 gm. LPN #111 stated Resident #20 was scheduled to receive Folic Acid (supplement) 1mg tablet but it was not available for administration which resulted in an omission of the medication.3.Review of the medical record for Resident #18 revealed an admission date of 10/21/25. Diagnoses included hemiplegia following stroke affecting non dominant side, other sequalae of stroke, stroke and hypertension.Review of the physician orders for Resident #18 revealed an order for a chewable 81 mg Aspirin tablet with a start date of 10/21/25.Observation on 11/05/25 at 8:17 A.M. LPN #105 prepared and administered Resident #18 81 mg EC Aspirin, Amlodipine (blood pressure) 10 mg tablet, Preservision (supplement) tablet, Flomax (prostate) 0.4 mg tablet and a Multivitamin (supplement) tablet.4.Review of the medical record for Resident #17 revealed an admission date of 02/18/22. The resident was admitted with diagnoses including Parkinson's disease, rheumatoid arthritis, Cushing's syndrome and diabetes mellitus type two.Observation and interview on 11/05/25 at 8:36 A.M. LPN #105 prepared and administered Resident #17 allopurinol (Gout) 300 mg tablet, carbidopa levodopa (Parkinson's Disease) 25-100 mg tablet, Eliquis (blood thinner) 5 mg tablet, two Gabapentin (nerve pain) 100 mg tablets, Folic Acid (supplement) 1 gram, Torsemide (diuretic) 10 mg tablet. LPN #105 then removed a container of polyethylene glycol 3350 (laxative) from the medication cart. She poured the powder into a liquid medication cup to the five milliliter (ml) level. She then emptied the contents into approximately eight ounces of water, stirred it and then delivered it along with the tablets. Immediately following administration LPN #105 acknowledged she did not use the cap of the polyethylene glycol to measure the powder and chose to use the liquid medication cup to measure the powered medication.Review of the directions for the polyethylene glycol 3350 supplied by the facility revealed the bottle cap was a measuring cup designed to contain 17 grams of powder when filled to the brim.Review of the undated facility policy, Administration of Medication revealed to verify the correct medication and right dose prior to administration. This deficiency represents non-compliance investigated under Complaint Number 2651090.