STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	366053	a. building _____ b. wing _____	**04/16/2026**

name of provider or supplier	street address, city, state, zip code
BERKELEY SQUARE RETIREMENT CEN	**100 BERKELEY DRIVE HAMILTON OH, 45013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000	INITIAL COMMENTS ANNUAL SURVEY ADMINISTRATOR: William Niehaus, #6075 CERTIFIED BED CAPACITY: 33 CENSUS IN HOUSE: 27 The following deficiencies are based on the annual survey completed 04/16/26.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

MSITCHAN | 05/06/2026

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.

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F 0657	Continued From page 1	F 0657		
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested	F 0657	THIS PLAN OF CORRECTION SERVES AS BERKELEY SQUARE'S CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF June 1, 2026. Without admitting or denying the validity or existence of the alleged deficiencies, Berkeley Square provides the following Plan of Correction: F657 The facility will continue to document completion of care conferences at the required intervals for all residents, including residents #04 & #15. To ensure compliance with this standard the following measures have be taken: 1. The social service designee and the inter- disciplinary team were re-educated by the administrator to the facility policy "Care Conference" on 4/29/26 and verbalized understanding. 2. Care conferences for resident #04 and resident #15 were conducted on or before 4/29/2026 by the interdisciplinary team. 3. Review of all other residents was conducted by the social service designee to validate and ensure that care conference schedule is up to date with timely care conferences scheduled for them on 4/15/2026. Audits of care conferences to be completed weekly for four weeks and then monthly after that by the social service designee. Documentation of the care conference including any identified concerns in the medical record. Administrator to validate audits/compliance and provide additional training as needed. Administrator will present results of these audits to QAPI committee for ongoing monitoring and further direction.	06/01/2026

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F 0657	Continued From page 2 by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This STANDARD is not met as evidenced by: Based on record review, interviews, and policy review the facility failed to document completion of care conferences at the required intervals. This affected two residents (#04 and #15) of 12 residents reviewed for care conferences. The facility census was 27. Findings include: 1. Review of the medical record of Resident #04 revealed an initial admission date of 10/14/16 and a re-admission date of 01/31/20. Diagnoses included Parkinson's disease with dyskinesia, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, transient cerebral ischemic attack, type II diabetes mellitus, and major depressive disorder. Review of the most recent significant change Minimum Data Set (MDS) assessment dated 01/28/26 revealed the	F 0657		

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F 0657	Continued From page 3 resident was cognitively intact, did not reject care, and did not wander. The resident was dependent on assistance for all Activities of Daily Living (ADL). Review of Resident #04's medical record revealed an annual MDS assessment was completed on 01/23/25, quarterly MDS assessments were completed on 04/23/25 and 05/16/25, a significant change MDS assessment was completed on 07/16/25, a quarterly MDS assessment was completed on 10/16/25, and a significant change MDS assessment was completed on 01/28/26. Further review of Resident #04's record revealed documentation of care conferences on 04/21/25 and 01/02/26. No additional care conference documentation was available in Resident #04's record. Interview on 04/14/26 at 4:18 P.M. with Unit Care Coordinator (UCC) #155 revealed no additional care conference documentation was available for the last 12 months for Resident #04. UCC #155 confirmed the only care conference documentation for the last 12 months were care conference notes dated 04/21/25 and 01/02/26. UCC #155 reported care conferences should be conducted quarterly with residents and family when possible. 2. Review of the medical record of Resident #15 revealed an initial admission date of 10/24/23 and a re-admission date of 12/17/25.	F 0657		

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F 0657	Continued From page 4 Diagnoses included aphasia following unspecified cerebrovascular disease, cerebral infarction, type II diabetes mellitus, unsteadiness on feet, difficulty in walking, coagulation defect, depression, and muscle weakness. Review of the most recent quarterly MDS assessment dated 01/09/26 revealed the resident had moderate cognitive impairment, did not reject care, and did not wander. The resident was independent for eating, setup assistance for oral hygiene, supervision assistance for upper body dressing, personal hygiene, bed mobility, sit to stand, transfers, walking ten feet, moderate assistance for toileting, bathing, lower body dressing, and mobilizing a manual wheelchair 50 feet. Further record review for Resident #15 revealed a quarterly MDS assessment dated 04/29/25, an annual MDS assessment dated 07/30/25, quarterly MDS assessments dated 10/30/25 and 01/09/26 and a quarterly MDS assessment in progress dated 04/10/26. Further record review of Resident #15 revealed a care conference was offered to Resident #15's representative on 08/16/24. It was documented that Resident #15's representative declined to attend this care conference. There was no documentation concerning care conferences in Resident #15's record for the most recent 12 months.	F 0657		

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F 0657	Continued From page 5 Interview on 04/14/26 at 4:18 P.M. with UCC #155 revealed no additional care conference documentation was available for Resident #15 other than the note offering a care conference to Resident #15's representative dated 08/16/24. UCC #155 reported care conferences should be conducted quarterly with residents and family when possible. Review of policy titled "Care Conference" with a most recent approval date of 06/23/25 revealed the purpose of a care conference was, "To review resident's comprehensive plan of care with the resident and/or significant others' participation, when possible." Further review of this policy revealed, "The facility will hold periodic care conferences and involve the resident, family, and interdisciplinary team and shall be part of the care planning process."	F 0657		

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F 0684	Continued From page 6	F 0684		
F 0684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and facility policy review, the facility failed to ensure residents received treatment in accordance with professional standards of practice when a resident was not reevaluated for hyperglycemia. This affected one (Resident #03) of five residents reviewed for unnecessary medicine. The facility census was 27. Findings Included: Medical record review revealed Resident #03 had an admission date of 01/05/26. Diagnoses included Alzheimer’s, diabetes mellitus type II, and depression Review of the current physician orders for Resident #03 included Humalog (an	F 0684	F684 The facility will continue to ensure all residents, including #03, receive treatment in accordance with professional standards of practice and reevaluated for hyperglycemia. To ensure compliance with this standard the following measures have been taken: 1. The director of nursing assessed resident #03, reviewed documentation and orders and found no ill effects immediately 4/16/26. 2. All licensed nurses were re-educated to facility policy "Blood Glucose Monitoring" by the Director of Nursing/designee in April 2026. 3. Audits of like-residents that require blood sugar checks to be completed by the director of nursing/designee two times a week for 4 weeks and then monthly after that to validate correct follow through when there is abnormally high blood glucose result. Administrator will bring results of these audits to the QAPI committee for ongoing monitoring and further direction.	06/01/2026

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F 0684	Continued From page 7 insulin medication to lower blood sugar) subcutaneous solution pen-injector 100 unit/milliliter (u/ml) per a sliding scale before meals, Lantus (an insulin medication to lower blood sugar) subcutaneous solution pen-injector 25 units daily, and lisinopril (a medication to treat high blood pressure) 5 milligrams (mg) by mouth once daily. Review of the Minimum Data Set assessment completed on 02/04/26 revealed Resident #03 was dependent on staff for transfers from bed to chair, requires substantial/maximal assistance with toileting hygiene, requires supervision/touch assistance with eating, and requires assistance with bathing. Review of Resident #03's progress note created on 04/15/26 at 12:19 A.M. by Registered Nurse (RN) #100 revealed the on call provider was notified of Resident #03’s blood glucose level of 532 milligrams per deciliter (mg/dL) and a new order to administer eight additional units of lispro (Humalog) and to recheck the blood glucose in 30 minutes. Review of the electronic medication administration record for Resident #03 revealed a blood sugar level of 532 mg/dL obtained on 4/14/26 at 9:00 P.M. An additional eight units of lispro given on 4/14/26 at 9:21 P.M. Interview with the Director of Nursing (DON) on 4/16/26 at 8:36 A.M. verified	F 0684		

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F 0684	Continued From page 8 there was no evidence in Resident #03's chart the residents blood glucose was re-evaluated after administration of additional insulin. The DON verified per facility policy concerning abnormal blood glucose, the resident should have been re-evaluated. Review of facility policy titled "Abnormal Blood Glucose Procedure" revised 8/24/16 revealed that signs and symptoms of hyperglycemia will be reported to the attending physician and that the nursing process step of evaluating will be included in progress note documentation.	F 0684		

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F 0756	Continued From page 9	F 0756		
F 0756 SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been	F 0756	F756 The facility will continue to ensure the pharmacy recommendations from the monthly drug regimen review by a licensed pharmacist are acted upon for all residents, including #08. To ensure compliance with this standard the following measures have been taken: 1. Resident #08 was assessed by the registered nurse and med review completed by 4/28/26. After review of resident's drug regime's, it was discovered that resident #8 had 2 separate medication recommendations on the same form, to be reviewed by two separate practitioners, pharmacy has been instructed and agreed to separate meds on individual forms. 2. Licensed nurses re-educated to facility policy "Drug Regimen Review" by Director of nursing/designee in April 2026 and no later than 5/8/26. Licensed nurses are responsible for ensuring the reviews and recommendations are given to the physician for timely review. 3. Review of all other current residents Drug Regimen orders completed by Director of nursing/designee on 4/16/26 to ensure recommendations were followed up on/reviewed by the physician and address concerns if needed. 4. Audit of Drug regime recommendations, pharmacy recommendations, and physician follow up to be completed weekly for four weeks by the Director of nursing/designee. Administrator will present results of these audits to the QAPI committee for ongoing monitoring and further direction.	06/01/2026

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F 0756	Continued From page 10 reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This STANDARD is not met as evidenced by: Based on medical record review, observation, review of the medication regimen review, staff interview, and policy review, the facility failed to ensure the pharmacy recommendations from the monthly drug regimen review by a licensed pharmacist were acted upon. This effected one (Resident #08) of five residents reviewed for medication regimen review. The facility census was 27. Findings Included:	F 0756		

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F 0756	Continued From page 11 Review of the medical record for Resident #08 revealed an admission date of 11/24/25. Diagnoses included Parkinson's, dementia, hypothyroidism. Review of the current physician orders included levothyroxine sodium (a hormone medication to treat the thyroid) tablet 150 microgram (mcg) once a day, buspirone hydrochloride (an antianxiety medication) 50 milligram (mg) by mouth twice a day, and losartan potassium (a medication to treat high blood pressure) tablet 100 mg by mouth once a day. Review of the Minimum Data Set assessment completed on 03/02/26 revealed Resident #08 utilized a walker and wheelchair for mobility and required setup/cleanup assistance with meals. Review of the medication regimen review for Resident #08 dated 11/25/2025 revealed the following recommendation from the consultant pharmacist: “Per manufacturer, levothyroxine should be administered consistently in the morning on an empty stomach, at least 30-60 minutes before food.” Further review revealed no specific physician response to the consultant pharmacist recommendation. Review of Resident #08's medication administration record for April 2026 revealed levothyroxine was to be given at 9:00 A.M.	F 0756		

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F 0756	Continued From page 12 Observation on 04/16/26 at 8:03 A.M. Resident #08 was eating breakfast in dinning area. Interview on 04/16/26 at 8:28 A.M., with Licensed Practical Nurse (LPN) #150 revealed she gave Resident #08 her levothyroxine 150 mcg to her while she was in the dining area eating breakfast. Interview on 04/16/26 at 8:48 A.M., with the Director of Nursing (DON) verified there was no evidence in Resident #08's medical record as to why or why not the consultant pharmacist recommendation from 11/25/25 was acted upon. Review of facility policy titled "Drug Regimen Review" dated 10/01/18 revealed a consulting pharmacist shall provide monthly reviews of medications of in-house residents upon admission and monthly and the reviews are sent to nursing and are addressed with the primary care provider or consulting specialist for review and follow-up.	F 0756		

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F 0812	Continued From page 13	F 0812		
F 0812 SS=F	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This STANDARD is not met as evidenced by:	F 0812	F812 The facility will continue to ensure food temperatures are completed before meals are served for all residents. To ensure compliance with this standard the following measures have been taken: 1. Immediately 4/15/26 culinary supervisor #224 was re-educated by Dietary Manager to this standard and policy "Food and Nutrition" which includes documentation of food temperatures. 2. All dietary staff have been re-educated to the standard and policy "Food and Nutrition" during the month of April 2026. 3. Audits of food temperature documentation to be completed by Dietary Manager 4 x per week for 4 weeks then weekly for 4 weeks. 4. Administrator to validate audits/compliance and provide additional training as needed. Administrator will present to QAPI committee for ongoing monitoring and further direction.	06/01/2026

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F 0812	Continued From page 14 Based on document review, staff interview, and policy review, the facility failed to ensure food temperatures were documented at the tray line for each meal served from the kitchenettes in the Harrison and McClellan Dining Rooms. This had the potential to affect all residents in the facility. The facility census was 27. Findings include: 1. Review of facility document titled "Trayline Taste & Temperature Log" with a revised date of September 2018 revealed that tray line food temperatures were not documented for meals served from the kitchenette in the Harrison Dining Room for dinner on 03/30/26, dinner on 03/31/26, lunch and dinner on 04/01/26, lunch and dinner on 04/02/26, dinner on 04/07/26, lunch and dinner on 04/08/26, and lunch and dinner on 04/10/26. Interview on 04/13/26 at 9:38 A.M., with the Senior Director of Culinary Services (SDCS) #224 verified the tray line food temperatures were not documented on the "Trayline Taste & Temperature Log" for meals served from the kitchenette in the Harrison Dining Room for dinner on 03/30/26, dinner on 03/31/26, lunch and dinner on 04/01/26, lunch and dinner on 04/02/26, dinner on 04/07/26, lunch and dinner on 04/08/26, and lunch and dinner	F 0812		

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	366053	a. building _____ b. wing _____	04/16/2026

name of provider or supplier	street address, city, state, zip code
BERKELEY SQUARE RETIREMENT CEN	100 BERKELEY DRIVE HAMILTON OH, 45013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0812	Continued From page 15 on 04/10/26. 2. Review of facility document titled "Trayline Taste & Temperature Log" with a revised date of September 2018 revealed that tray line food temperatures were not documented for meals served from the kitchenette in the McClellan Dining Room for dinner on 04/01/26, breakfast and lunch on 04/02/26, and lunch and dinner on 04/07/26. Interview on 04/13/26 at 9:46 A.M., with the SDCS #224 verified the tray line food temperatures were not documented on the "Trayline Taste & Temperature Log" for meals served from the kitchenette in the McClellan Dining Room for dinner on 04/01/26, breakfast and lunch on 04/02/26, and lunch and dinner on 04/07/26. A follow-up interview on 04/15/26 at 3:02 P.M., with the SDCS #224 revealed the revised date for the currently used document titled "Trayline Taste & Temperature Log" was September 2018. Review of a policy titled "Food and Nutrition" with an approval date of 09/07/21 revealed, "The facility must store, prepare, distribute, and serve food in accordance with professional standards for food service safety."	F 0812		