STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365562	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madeira Healthcare Center	6940 Stiegler Lane Cincinnati, OH 45243

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record reviews, interviews, and policy review, the facility failed to conduct quarterly care conferences. This affected eight (#2, #7, #9, #22, #33, #39, #60, and #63) out of eight residents reviewed for care planning. The facility census was 82. Findings include: 1. Review of the medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included Alzheimer's Disease, depression, anxiety disorder, hyperlipidemia, and obsessive-compulsive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had intact cognition. Resident #39 was assessed to require setup assistance for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and bed mobility, and supervision for transfer. Review of the care conference forms revealed care conferences were held for Resident #39 on 01/24/24 and 06/19/24. Review of the progress notes from 08/01/24 to 03/26/25 revealed no documentation related to care conferences held for Resident #39. Interview on 03/26/25 at 3:55 P.M. with Regional Director of Clinical Operations (RDCO) #200 verified the last documented care conference for Resident #39 was 06/19/24. 40471 2. Review of records for Resident #2 revealed an admitted [DATE] with diagnoses including end stage renal disease, heart transplant, kidney transplant, and Alzheimer's Disease. Review of MDS dated [DATE] revealed Resident #2 had severe cognitive impairment and required assistance with activities of daily living (ADLs). Review of progress notes revealed no documentation of care conferences being performed. Interview on 03/25/25 at 1:42 P.M. Regional Director of Clinical Operations (RDCO) #200 verified the lack of documentation for care conferences as required. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of records for Resident #7 revealed an admitted [DATE] with diagnoses including multiple sclerosis (MS), extended spectrum beta lactamase (ESBL) resistance, and contracture of hand. \ Review of MDS dated [DATE] revealed Resident #7 had some cognitive impairment. Further review of the medical record revealed care conferences documented on 05/03/22 and 02/09/23, no care conferences were documented for 2024 or 2025. Interview on 03/25/25 at 1:42 P.M. Regional Director of Clinical Operations (RDCO) #200 verified the lack of documentation for care conferences as required. 4. Review of Resident #33's records revealed an admitted [DATE] with diagnoses including cerebral infarction, type two diabetes (DM2), and end stage renal disease. Review of MDS dated [DATE] revealed Resident #33 had significant cognitive impairment and required assistance with activities of daily living (ADLs). Review of progress notes revealed one documented care conference dated 07/30/24. Interview on 03/25/25 at 1:42 P.M. RDCO #200 verified the lack of documentation for care conferences as required. 5. Review of records for Resident #63 revealed an admitted [DATE] with diagnoses including schizophrenia and suicidal ideation. Review of MDS dated [DATE] revealed Resident #63 was cognitively intact and required assistance with ADLs. Review of progress notes revealed care conferences on 08/24/22 and 04/17/24. Interview on 03/25/25 at 1:42 P.M. RDCO #200 verified the lack of documentation for care conferences being performed as required. 49771 6. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses of non-infective gastroenteritis and colitis, end-stage renal disease with dependence on renal dialysis, diabetes mellitus type II, cerebral infarction with right (dominant side) hemiparesis and hemiplegia, kidney transplant status and the need for assistance with personal care. Review of the MDS assessment dated [DATE] revealed Resident #9 had intact cognition and was always incontinent of bowel and bladder. The resident required supervision with eating and oral and personal hygiene, was dependent for toileting, bathing and dressing and maximal assistance with bed mobility and transfers. Review of the medical record revealed no documentation the facility completed an initial care conference with Resident #9 and/or the resident's representative. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/26/25 at 12:34 with Resident #9 revealed no knowledge of the facility completing an initial care conference with her. Interview on 03/26/25 at 2:12 P.M. with the Regional Director of Clinical Operations #200 revealed she could not locate documentation the facility completed an initial care conference with Resident #9. Interview on 03/26/25 at 4:16 P.M. with Social Services Director #36 verified an initial care conference was not held with Resident #9. 7. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses of end-stage renal disease with dependence on renal dialysis, diabetes mellitus type II, gas gangrene and hypertension. Review of the MDS quarterly assessment dated [DATE] revealed Resident #22 had intact cognition and was frequently incontinent of bowel and bladder. The resident required set up assistance with eating, supervision with oral hygiene and bed mobility, maximal assistance with toileting, bathing, dressing and personal hygiene and dependent for transfers. Review of the medical record revealed no documentation the facility completed care conferences with Resident #22 in the first (January, February and March), second (April, May and June), third (July, August and September) and fourth (October, November and December) quarters of 2024. Interview on 03/26/25 at 2:12 P.M. with the Regional Director of Clinical Operations #200 revealed she could not locate documentation the facility completed care conferences with Resident #9 in the first (January, February and March), second (April, May and June), third (July, August and September) and fourth (October, November and December) quarters of 2024. Interview on 03/26/25 at 4:16 P.M. with Social Services Director #26 verified the facility had no documentation of care conferences for Resident #22 in the first (January, February and March), second (April, May and June), third (July, August and September) or fourth (October, November and December) quarters of 2024. 8. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE] with diagnoses of Down syndrome, anoxic brain damage, tracheostomy, gastrostomy and cerebrovascular disease with right (dominant side) hemiplegia and hemiparesis. Review of the MDS quarterly assessment dated [DATE] revealed Resident #60 had severe cognitive impairment and was always incontinent of bowel and bladder. The resident was dependent for eating (gastrostomy tube), oral and personal hygiene, toileting, bathing, dressing, bed mobility and transfers. Review of the medical record revealed no documentation the facility completed care conferences with Resident #60 in the first (January, February and March), second (April, May and June), third (July, August and September) and fourth (October, November and December) quarters of 2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/26/25 at 2:12 P.M. with the Regional Director of Clinical Operations #200 revealed she could not locate documentation the facility completed care conferences with Resident #60 in the first (January, February and March), second (April, May and June), third (July, August and September) and fourth (October, November and December) quarters of 2024. Interview on 03/26/25 at 4:16 P.M. with Social Services Director #26 verified the facility had no documentation of care conferences for Resident #60 in the first (January, February and March), second (April, May and June), third (July, August and September) or fourth (October, November and December) quarters of 2024. Review of the policy titled, Plan of Care Overview, dated 2017, revealed residents/representatives will be informed of their plan of care in the most understandable manner possible; that residents/representatives will be offered opportunities to voice their view; and that residents/representatives will have the right to participate in the development and implementation of his/her own plan of care. Additionally, the facility will review care plans quarterly and/or with significant changes in care and schedule the meeting to accommodate a resident's representative that may include conference calls, video conference sessions or live sessions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on observation, staff interviews, and policy review, the facility failed to prevent food contamination. This affected one (Resident #7) of two residents observed being fed in the dining room. The facility census was 82. Findings include: Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, dysphagia, morbid obesity and major depressive disorder. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #7 had moderate cognitive impairment and was always incontinent of bowel and had a urostomy. The resident was dependent for eating, oral and personal hygiene, toileting, bathing, dressing, bed mobility and transfers. Observation on 03/24/25 at 1:02 P.M. of the lunch meal service revealed Resident #7 was being fed by Certified Nursing Assistant (CNA) #8. On the resident's plate was a cheese quesadilla, mashed potatoes and mixed vegetables. During the observation, CNA #7 used his bare fingers to tear off a bite sized piece of the quesadilla and then proceeded to stick it with a fork, add some sour cream and place it in the resident's mouth. Interview on 03/24/25 at 1:03 P.M. with CNA #8 verified he used his bare fingers to tear off a bite sized piece of the cheese quesadilla and feed it to Resident #7. Interview on 03/24/25 at 2:12 P.M. with the Regional Director of Clinical Operations #200 verified staff should not handle resident's food with their bare fingers. Review of the policy titled, Meal Distribution, revised 02/23, revealed proper food handling techniques to prevent contamination will be used for point of service dining.