STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365733	A. Building B. Wing	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Margaret Hall	1960 Madison Road Cincinnati, OH 45206

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, interview, and facility policy, the facility failed to treat a resident with dignity and respect. This affected one (Resident #28) of one reviewed for dignity and respect. The facility census was 72. Findings include: Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included fibromyalgia, hyperlipidemia, dorsalis, hypothyroidism, compression fracture, moderate calorie malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had a Brief Interview of Mental Status of 15 that indicated she was cognitively intact. Resident #28 required setup assistance for eating and supervision oral hygiene. Resident #28 was dependent upon staff for toileting, bathing, and transfers. Resident #28 required substantial maximum assistance for bed mobility. Resident #28 was frequently incontinent of bowel and bladder. Review of the verbal disciplinary action dated 01/12/24 revealed the Administrator informally met with State tested Nurse Aide (STNA) #115 on 01/10/24. The discussion focused on good customer service and progression communication. It was explained to STNA #115 that there was a reason to believe she needed to be more prompt and change the delivery of resident services in a more positive fashion. STNA #115 signed the document. Interview and observation at 01/24/24 at 1:56 P.M. revealed STNA #115 providing incontinence care to Resident #28. STNA #115 with a loud voice yelled at Resident #28 to lift her feet from the sit to stand lift. STNA #115 appeared to be in a rush and was pushing the sit to stand lift around to get the resident back in her recliner quickly. Interview on 01/24/24 at 2:59 P.M. with Resident #28 revealed she felt staff were in a rush and treated residents like children. Review of the consecutive employee warning report dated 01/24/24 documented by Human Resource Director #97 revealed an investigation would be started and disciplinary action would be taken to STNA #115, who was disrespectful to Resident #28. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Dignity Policy, not dated, revealed residents are always treated with dignity and respect. Residents may exercise their rights without interference, coercion, discrimination or reprisal from any person or entity associated with the facility. This deficiency represents non-compliance investigated under Complaint Number OH00149928.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on record review, observation, interview, and facility policy, facility failed to ensure a resident had access to their call light. This affected one (Resident #71) of three residents reviewed for call lights. The facility census was 72. Findings include: 1. Review of the medical record for Resident #71 revealed an admitted [DATE]. Diagnoses included respiratory disorders diseases, acute respiratory failure with hypoxia, anxiety disorder, and chronic atrial fibrillation. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #71 was cognitively intact. Resident #71 was dependent upon staff for transfers, bathing, lower body dressing, and bed mobility. Observation and interview on 01/22/24 at 12:04 P.M. with Resident #71 verified she was sitting in her wheelchair and unable to reach the call light, which was on her bed, against the wall. Interview on 01/22/4 at 12:06 P.M. with Licensed Practical Nurse (LPN) #56 verified Resident #71's call light was in between the bed and wall and could not be reached by Resident #71. Review of facility policy titled, Answering the Call Light, not dated, revealed when the resident was in bed or confined to a chair be sure the call light was within reach of the resident.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review, staff interview, and policy review, the facility failed to ensure advance directives were documented appropriately. This affected one (#37) out of eight residents reviewed for advance directives. The census was 72. Findings include: Review of the medical record for Resident #37 revealed she was admitted to the facility on [DATE]. Diagnoses included polyneuropathy, type two diabetes mellitus with diabetic polyneuropathy, chronic obstructive pulmonary disease, acute embolism and thrombosis of unspecified deep veins of left lower extremity, Alzheimer's Disease, sleep apnea, acute kidney failure, pure hypercholesterolemia, congestive heart failure, cardiomyopathy, hypercalcemia, overactive bladder, hypothyroidism, mixed hyperlipidemia, and anemia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 had severely impaired cognition. This resident was assessed to require moderate assistance with eating, oral hygiene, and personal hygiene, and maximal assistance with toileting, bathing, dressing, bed mobility, and transfer. Review of the physician orders revealed an order dated 11/24/23 for Do Not Resuscitate (DNR) Comfort Care Arrest. Review of the electronic health record and paper chart revealed no evidence of a completed DNR form. Interview on 01/23/24 at 11:08 A.M. with Licensed Practical Nurse (LPN) #820 confirmed Resident #37 had an order for DNR, but there was not a completed form in either the electronic health record or paper chart. Review of the facility policy titled, Advance Directives, revised 09/2022, revealed copies of advance directives are obtained and readily retrievable by facility staff.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on interview and record review, the facility failed to ensure an injury of unknown origin was reported to the state agency. This affected one (#51) of one resident reviewed for abuse. The facility census was 72. Findings include: Review of Resident #51's medical record revealed Resident #51 admitted to the facility on [DATE] with diagnoses including unspecified dementia unspecified severity without behavioral disturbance psychotic disturbance, mood disturbance, and anxiety, muscle weakness, gastro esophageal reflux disease without esophagitis, chronic rhinitis, constipation, unspecified osteoarthritis, hyperglycemia, adult failure to thrive, and diarrhea. Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and required set up assistance with eating, and oral hygiene. Resident #51 required maximal assistance with toileting, showering, transfers, upper body dressing, lower body dressing, putting on and taking footwear, personal hygiene, and rolling left and right. Resident #51 required supervision with sitting to lying, lying to sitting, and sitting to standing. Review of Resident #51's hospice care plan dated 05/09/23 revealed Resident #51 had a terminal prognosis related to a terminal diagnosis of protein calorie malnutrition. Interventions included observe residents closely for signs of pain, administer pain medications as ordered, and notify the physician immediately if there is breakthrough pain. Review of Resident #51's pain tool dated 01/10/24 revealed Resident #51 had no complaints of pain other than baseline pain in shoulders. Resident #51 was on routine Tylenol. Review of Resident #51's Medication Administration Record from 01/01/24 to 01/16/24 revealed Resident #51 had a pain level of ten on 01/12/24 and on 01/16/24. All other daily pain levels were listed as zero. Review of Resident #51's progress note dated 01/12/24 at 8:43 A.M. revealed Resident #51 was noted with severe pain to right shoulder. Resident #51 was noted to be tearful related to pain and Resident #51 was not able to lift her right arm without severe pain. Resident #51 took Tylenol with water well. A call was placed to Resident #51's Power of Attorney (POA) related to the shoulder and Resident #51's POA agreed to the facility ordering an x-ray of the right shoulder. The physician was made aware, and a call placed to hospice. An x-ray was ordered. Review of the portable service requisition dated 01/12/24 revealed a complete two view shoulder x-ray for pain in the right shoulder with as soon as possible priority was requested. Review of Resident #51's progress note dated 01/15/24 at 5:22 P.M. revealed Resident #51 was out of the facility at 3:45 P.M. to the emergency room . (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's physician order dated 01/15/24 revealed a two view x-ray of the right shoulder was ordered for pain. Review of Resident #51's right shoulder complete two view x-ray dated 01/15/23 revealed demineralization and humeral head articulating with the expanded lower glenoid fossa thereby increasing acromiohumeral distance to 2.85 centimeters (cms). Review of Resident #51's hospital note dated 01/15/24 revealed Resident #51 presented to the emergency department for evaluation of fall with right shoulder pain. Per the triage note, the resident fell two weeks ago and had since had right shoulder pain. Resident #51 had an x-ray on 01/15/24 that showed up with a dislocation of the shoulder. Resident #51 stated her shoulder was okay and denied pain elsewhere. The joint was numbed with lidocaine and a reduction was attempted using inferior traction and abduction. The shoulder was then placed in a sling. Review of Resident #51's progress note dated 01/16/24 at 2:42 P.M. revealed the Director of Nursing (DON) spoke to Resident #51's POA and she stated Resident #51 had always had pain or discomfort related to her shoulders. Resident #51's POA had been reluctant with getting x-rays for Resident #51 due to radiation per hospice. Resident #51 did not remember when she could have dislocated or exactly when pain was present. Resident #51's POA believed it may have been due to her pulling up from bed to walker. Resident #51's last pain assessment noted shoulder pain which was baseline for patient. Resident #51's pain had been intermittent since and she is being managed by hospice and Ativan and Tylenol were added at beginning of month per family request. Resident #51 was currently wearing a sling to immobilize shoulder and the facility would continue to monitor for latent pain. Review of Resident #51's physician statement dated 01/24/24 revealed Physician #850 determined Resident #51's dislocated shoulder was the result of her chronic shoulder osteoarthritis. According to the POA, she pronates to the shoulder when she sleeps, and she has a history of generalized pain to shoulders. According to hospice and the emergency room physician, the dislocated shoulder was due to chronic issues. Reviewing the hospital diagnostics and in house x-ray, the tendons and connective tissue in the shoulder likely deteriorated leading to the possibility of dislocation without any forced trauma. Review of the facility's Self Reported Incidents (SRIs) from 01/01/24 to 01/24/24 revealed no SRIs were filed regarding Resident #51's dislocated right shoulder found on 01/15/24. Interview with the Director of Nursing (DON) on 01/25/24 at 11:31 A.M. verified Resident #51's dislocated right shoulder was not reported to the state agency as an SRI. The DON verified the hospital record stated Resident #51's shoulder dislocation was from a possible fall and Resident #51's progress note dated 01/16/24 stated that Resident #51 was unable to state how the injury occurred. The DON also confirmed that the 01/16/24 progress note also stated Resident #51's dislocated shoulder could have been caused by her laying on her shoulder or her pulling up from her bed to her walker. The DON stated she was in contact with Physician #850 and Physician #850 spoke with hospice, and the emergency room physician in order to determine Resident #51's dislocated right shoulder was pathological and caused by her osteoarthritis. The DON also verified that an investigation was not completed and staff that worked with Resident #51 or additional residents were not interviewed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's abuse, neglect, exploitation, or misappropriation reporting and investigating policy dated April 2021 revealed all reports of abuse including injuries of unknown origin are reported to local, state, and federal agencies as required by current regulations and thoroughly investigated by management. The administrator or the individual making the allegation will immediately report their suspicion to the state licensing agency responsible for surveying and licensing the facility. Immediately is defined as within two hours of an allegation involving abuse or resulted in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment or exploitation of a resident or misappropriation of resident property dated 08/30/19 revealed injuries of unknown source were defined as the source of the injury was not observed by any person or could not be explained by the resident and the injury was suspicious because of the extent of the injury, location of the injury, the number of injuries observed at a particular point in time or the incident of injuries over time. Upon receipt of the report, the Administrator or designee must report to state or federal agencies as applicable any suspected injuries of unknown origin within 24 hours of the receipt of the report. The DON or designee shall initiate an investigation as soon as possible.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on interview and record review, the facility failed to ensure an injury of unknown origin was thoroughly investigated. This affected one (#51) out of one resident reviewed for abuse. The facility census was 72. Findings include: Review of Resident #51's medical record revealed Resident #51 admitted to the facility on [DATE] with diagnoses including unspecified dementia unspecified severity without behavioral disturbance psychotic disturbance, mood disturbance, and anxiety, muscle weakness, gastro esophageal reflux disease without esophagitis, chronic rhinitis, constipation, unspecified osteoarthritis, hyperglycemia, adult failure to thrive, and diarrhea. Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and required set up assistance with eating, and oral hygiene. Resident #51 required maximal assistance with toileting, showering, transfers, upper body dressing, lower body dressing, putting on and taking footwear, personal hygiene, and rolling left and right. Resident #51 required supervision with sitting to lying, lying to sitting, and sitting to standing. Review of Resident #51's hospice care plan dated 05/09/23 revealed Resident #51 had a terminal prognosis related to a terminal diagnosis of protein calorie malnutrition. Interventions included observe residents closely for signs of pain, administer pain medications as ordered, and notify the physician immediately if there is breakthrough pain. Review of Resident #51's pain tool dated 01/10/24 revealed Resident #51 had no complaints of pain other than baseline pain in shoulders. Resident #51 was on routine Tylenol. Review of Resident #51's Medication Administration Record from 01/01/24 to 01/16/24 revealed Resident #51 had a pain level of ten on 01/12/24 and on 01/16/24. All other daily pain levels were listed as zero. Review of Resident #51's progress note dated 01/12/24 at 8:43 A.M. revealed Resident #51 was noted with severe pain to right shoulder. Resident #51 was noted to be tearful related to pain and Resident #51 was not able to lift her right arm without severe pain. Resident #51 took Tylenol with water well. A call was placed to Resident #51's Power of Attorney (POA) related to the shoulder and Resident #51's POA agreed to the facility ordering an x-ray of the right shoulder. The physician was made aware, and a call placed to hospice. An x-ray was ordered. Review of the portable service requisition dated 01/12/24 revealed a complete two view shoulder x-ray for pain in the right shoulder with as soon as possible priority was requested. Review of Resident #51's progress note dated 01/15/24 at 5:22 P.M. revealed Resident #51 was out of the facility at 3:45 P.M. to the emergency room . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's physician order dated 01/15/24 revealed a two view x-ray of the right shoulder was ordered for pain. Review of Resident #51's right shoulder complete two view x-ray dated 01/15/23 revealed demineralization and humeral head articulating with the expanded lower glenoid fossa thereby increasing acromiohumeral distance to 2.85 centimeters (cms). Review of Resident #51's hospital note dated 01/15/24 revealed Resident #51 presented to the emergency department for evaluation of fall with right shoulder pain. Per the triage note, the resident fell two weeks ago and had since had right shoulder pain. Resident #51 had an x-ray on 01/15/24 that showed up with a dislocation of the shoulder. Resident #51 stated her shoulder was okay and denied pain elsewhere. The joint was numbed with lidocaine and a reduction was attempted using inferior traction and abduction. The shoulder was then placed in a sling. Review of Resident #51's progress note dated 01/16/24 at 2:42 P.M. revealed the Director of Nursing (DON) spoke to Resident #51's POA and she stated Resident #51 had always had pain or discomfort related to her shoulders. Resident #51's POA had been reluctant with getting x-rays for Resident #51 due to radiation per hospice. Resident #51 did not remember when she could have dislocated or exactly when pain was present. Resident #51's POA believed it may have been due to her pulling up from bed to walker. Resident #51's last pain assessment noted shoulder pain which was baseline for patient. Resident #51's pain had been intermittent since and she is being managed by hospice and Ativan and Tylenol were added at beginning of month per family request. Resident #51 was currently wearing a sling to immobilize shoulder and the facility would continue to monitor for latent pain. Review of Resident #51's physician statement dated 01/24/24 revealed Physician #850 determined Resident #51's dislocated shoulder was the result of her chronic shoulder osteoarthritis. According to the POA, she pronates to the shoulder when she sleeps, and she has a history of generalized pain to shoulders. According to hospice and the emergency room physician, the dislocated shoulder was due to chronic issues. Reviewing the hospital diagnostics and in house x-ray, the tendons and connective tissue in the shoulder likely deteriorated leading to the possibility of dislocation without any forced trauma. Review of the facility's Self Reported Incidents (SRIs) from 01/01/24 to 01/24/24 revealed no SRIs were filed regarding Resident #51's dislocated right shoulder found on 01/15/24. Interview with the Director of Nursing (DON) on 01/25/24 at 11:31 A.M. verified Resident #51's dislocated right shoulder was not reported to the state agency as an SRI. The DON verified the hospital record stated Resident #51's shoulder dislocation was from a possible fall and Resident #51's progress note dated 01/16/24 stated that Resident #51 was unable to state how the injury occurred. The DON also confirmed that the 01/16/24 progress note also stated Resident #51's dislocated shoulder could have been caused by her laying on her shoulder or her pulling up from her bed to her walker. The DON stated she was in contact with Physician #850 and Physician #850 spoke with hospice, and the emergency room physician in order to determine Resident #51's dislocated right shoulder was pathological and caused by her osteoarthritis. The DON also verified that an investigation was not completed and staff that worked with Resident #51 or additional residents were not interviewed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's abuse, neglect, exploitation, or misappropriation reporting and investigating policy dated April 2021 revealed all reports of abuse including injuries of unknown origin are thoroughly investigated. The individual conducting the investigation as a minimum will interview staff members who had contact with the resident during the period of the alleged incident, and interview other residents to whom the accused employee provides care or services. Review of the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment or exploitation of a resident or misappropriation of resident property dated 08/30/19 revealed injuries of unknown source were defined as the source of the injury was not observed by any person or could not be explained by the resident and the injury was suspicious because of the extent of the injury, location of the injury, the number of injuries observed at a particular point in time or the incident of injuries over time. Upon receipt of the report, the Administrator or designee must report to state or federal agencies as applicable any suspected injuries of unknown origin within 24 hours of the receipt of the report. The DON or designee shall initiate an investigation as soon as possible.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39967 Based on interview and record review, the facility failed to ensure resident care plans reflected the residents current status and behaviors. This affected one (#70) of one resident reviewed for care planning. The facility census was 72. Findings include: Review of Resident #70's medical record revealed Resident #30 admitted to the facility on [DATE] with diagnoses including other specified disorders of the brain, repeated falls, cognitive communication deficit, dysphagia, hypertension, hyperlipidemia, and muscle weakness. Review of Resident #70's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and required set up assistance with eating, and oral hygiene. Resident #70 was dependent with toileting, lower body dressing and sitting to lying. Resident #70 also required maximal assistance with showering, personal hygiene, and putting on and taking off shoes, and moderate assistance with upper body dressing, and rolling left to right. Review of Resident #70's progress note dated 12/29/23 at 7:29 P.M. revealed Resident #70 was beating at the tray table side handle and tried to wrap his call light around his neck. Staff continued to try to meet the resident's needs and check on him frequently related to safety. Review of Resident #70's progress note dated 01/01/24 6:22 P.M. revealed charge nurse elaborated and reported Resident #70 had the call cord around his neck loosely and the resident was offered a pin clip to the sheets but refused. Resident #70 was yelling at staff and will continually play with the call bell when he is in the room. The Power of Attorney (POA) stated his brother would do this because he did not want anyone to take the call light and he had a fear of not having a call light. No suicidal behavior was noted according to the POA. Review of Resident #70's behavior care plan dated 12/12/23 revealed the resident used psychotropic medications related to behavior management, adjustment disorder with mixed anxiety and depressed mood. Further review of Resident #70's care plan revealed no information or interventions related to Resident #70's behavior of wrapping the call light cord around his neck or him being fearful of staff taking his call light. Interview with Licensed Practical Nurse (LPN) Unit Manager #900 on 01/24/24 at 4:50 P.M. verified Resident #70 had wrapped the call light cord around his neck in the past due to the resident being afraid that the call light would be taken from him. LPN Unit Manager #900 also stated Resident #70 had a history of playing with his call light. LPN Unit Manager #900 verified Resident #70 continued to have a call light cord in his room and Resident #70 did not have a care plan for his behaviors related to playing with the call light cord, fear of the call light being taken, or wrapping the call light cord around his neck.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, observation, and staff interview, the facility failed to ensure a resident had access to hearing aids. This affected one (Resident #43) of one resident reviewed for hearing. The facility census was 72. Findings include: Review of Resident #43's medical record revealed Resident #43 admitted to the facility on [DATE] with diagnoses including urinary tract infection, radiculopathy, pain, lumbago with sciatica, other chronic pain, hypertension, other abnormalities of gait and mobility, unspecified fracture of shaft of unspecified tibia subsequent encounter for closed fracture with healing, unspecified fracture of shaft of unspecified fibula subsequent encounter for closed fracture with routine healing and generalized anxiety disorder. Review of Resident #43's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and required set up assistance with oral hygiene. Resident #43 was independent with eating and dependent with toileting, putting on and taking off footwear, personal hygiene, sitting to standing, chair transfers, and toileting transfers. Resident #43 required maximal assistance with showering, upper body dressing, lower body dressing, rolling left to right, sitting to lying, and lying to sitting. Resident #43 was noted with moderate difficulty with hearing and Resident #43 used hearing aids. Review of Resident #43's hearing care plan dated 07/26/22 revealed Resident #43 had a communication problem related to a hearing deficit and had bilateral hearing aids. Interventions included ensure bilateral hearing aids are in place. Review of Resident #43's audiology consultation dated 04/19/21 revealed Resident #43 had moderately severe bilateral sensorineural hearing loss. Resident #43 had bilateral nuear canal aids which were under powered. Results will be discussed with family. Observation of Resident #43 on 01/22/24 at 12:06 P.M. revealed Resident #43 was not able to respond to interview questions due to difficulty hearing. Resident #43 did not have hearing aids in place. Interview with Licensed Practical Nurse (LPN) Unit Manager #900 on 01/24/24 at 12:33 P.M. revealed she was not aware Resident #43 had hearing aids and Resident #43 never wore hearing aids at the facility. LPN Unit Manager #900 stated she spoke with Resident #43 on 01/24/24 regarding the 04/19/21 audiology appointment and her hearing aids and Resident #43 stated that she had been to several audiology appointments and refused additional testing. LPN Unit Manager #900 reported Resident #43 told her that her family would love for her to use hearing aids and she wanted to be put back on the list to see audiology. LPN Unit Manager #900 verified Resident #43 did not have a care plan for the refusal of her hearing aids and verified the care plan stated Resident #43 had bilateral hearing aids. LPN Unit Manager #900 confirmed Resident #43 never used her hearing aids, and Resident #43 had difficulty hearing.

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	365733	A. Building B. Wing	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Margaret Hall	1960 Madison Road Cincinnati, OH 45206

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review, and staff interview, the facility failed to ensure residents received proper staff assistance with care to prevent falls. This affected one (#66) out of seven residents reviewed for accidents. The facility census was 72. Findings include: Review of the medical record for Resident #66 revealed she was admitted to the facility on [DATE]. Diagnoses included sciatica, hepatic encephalopathy, vitamin d deficiency, insomnia, bipolar disorder, atrial fibrillation, morbid obesity due to excess calories, anemia, hypokalemia, anxiety disorder, depression, and post-traumatic stress disorder. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #66 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 14. The resident was assessed to require setup assistance for eating, oral hygiene, maximal assistance for bathing and upper body dressing, and was dependent for toileting, lower body dressing, personal hygiene, bed mobility, and transfer. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #66 required extensive physical assistance of two staff for bed mobility and toileting. Review of the plan of care initiated 11/24/23 revealed Resident #66 had self-care and mobility deficits related to weakness, impaired mobility, hepatic encephalopathy, and seizure disorder. Interventions included substantial/maximal assistance of two staff for bed mobility and dependent assistance for toileting. Review of the progress note dated 12/21/23 revealed the nurse entered Resident #66's room to administer medications. The note indicated the resident was turned on her side and was getting cleaned up. The nurse went to put the medications down on the table and heard the resident screaming. When the nurse turned around, the resident's legs were hanging off the bed, her knees were on the floor, and her arms were hanging onto the side of the bedrail. The resident was lowered to the ground and turned on her back. Upon assessment, the resident was found to have blood on her upper right chest area and was screaming out in pain, and stated she wanted to go to the emergency room . Review of the progress note dated 12/21/23 revealed Resident #66 returned from the hospital with abrasions to the abdomen, but no major injuries. Review of the fall investigation dated 12/21/23 revealed Resident #66's leg fell off the bed while she was being changed, which caused her to roll off the bed. Review of the witness statement dated 12/21/23 by State tested Nursing Assistant (STNA) #830 revealed Resident #66 rolled over to the left side while STNA #830 was providing personal care and continued to slide off the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/25/24 at 2:27 P.M. with Licensed Practical Nurse (LPN) #102 revealed she entered the room to administer medications to Resident #66, and the aide had the resident on her side to provide incontinence care. LPN #102 stated she was going to help, but before she was able to set down the medications and turn around to assist, she heard screaming. LPN #102 expressed when she turned around, she discovered Resident #66 holding onto the bedrail on her knees with her elbows on the mattress. LPN #102 reported Resident #66 was lowered to the floor and propped up with pillows until emergency services arrived. LPN #102 confirmed Resident #66 required the assistance of two staff for personal care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record, observation, interview, and facility policy, facility failed to provide timely incontinence care for two residents (#328 and #28) of four reviewed for incontinence care. Facility census was 72. Findings include: 1. Review of the medical record revealed Resident #328 was admitted on [DATE]. Diagnoses included aphasia, cognitive communication deficit, osteoporosis, and hypertension. Review of the plan of care dated 01/10/24 revealed Resident #328 was at risk for incontinence related to impaired mobility, cerebral vascular accident, cognitive communication deficit, pain related to compression fracture T-11-T12, and potential adverse side effects of medication received. Interventions included check Resident #328 routinely and as required for incontinence. Wash, rinse, and dry perineum during care. Resident #328 used an incontinent brief. Change clothing as needed after incontinence episodes. Monitor for signs and symptoms of urinary tract infection and report to physician. Review of the bowel and bladder program screener dated 01/11/24 revealed Resident #328 was incontinent of stool 4-6 times a week. Transfer to toilet or commode and adjust clothing and wipe assistance. The resident was never aware of the need to toilet. Condition of skin on genital, perineum, and buttocks was some blanchable redness. Review of the Braden scale for predicting pressure ulcer risk dated 01/10/24 revealed Resident #328 was at moderate risk for developing pressure ulcers. Resident #328 was chairfast and skin was exposed to moisture that required linens to be changed once a shift. Resident #328's sensory perception was very limited and she could not communicate discomfort except moaning or restlessness or has a sensory impairment which limits the ability to feel pain or discomfort over half of body. Observation on 01/22/24 at 11:15 A.M. revealed Resident #328 in bed uncovered. Resident #328's depend was observed to be heavily saturated and there was feces on her left leg and on the flat sheet. Observation and interview on 01/22/24 at 2:06 P.M. revealed Occupational Therapy Assistant (OTA) #725 and Physical Therapy Assistant (PTA) #710 provided incontinence care to Resident #328. OTA #725 and PTA #710 both confirmed Resident #328 had feces on her flat sheet, leg, gown, and a cloth chuck under her bottom. The cloth chuck was heavily saturated with urine and feces. Resident #328's incontinent brief was heavily saturated with urine and no feces. Interview on 01/22/24 at 1:59 P.M. with State tested Nurse Aide (STNA) #117 revealed she never checked or provided incontinence care for Resident #328. Interview on 01/22/24 at 2:11 P.M. with STNA #50 revealed she checked and changed Resident #328 last at 9:32 A.M. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/24 at 5:31 P.M. with STNA #715 revealed she did not take care of Resident #328. 2. Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included fibromyalgia, hyperlipidemia, dorsalis, hypothyroidism, compression fracture, moderate calorie malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had a Brief Interview of Mental Status of 15 that indicated she was cognitively intact. Resident #28 required setup assistance for eating and supervision oral hygiene. Resident #28 was dependent upon staff for toileting, bathing, and transfers. Resident #28 required substantial maximum assistance for bed mobility. Resident #28 was frequently incontinent of bowel and bladder. Review of the plan of care dated 12/14/23 revealed Resident #28 had potential for complications related to episodes of incontinence. Interventions included encourage fluids, ensure the resident had an unobstructed path to the bathroom, may straight cath for urinary retention, notify and document signs and symptoms of urinary tract infection, pericare after each incontinent episode, and utilize adult incontinent brief. Interview on 01/24/24 at 10:35 A.M. with Resident #28 revealed she did not receive good incontinence care and was soaked when they came to change her incontinent brief. Resident #28 stated she was very weak and unable to stand for long periods of time to go to the bathroom and toilet. Resident #28 stated staff members cannot take her to the bathroom due to the sit and stand lift not fitting in the width of the door. Interview on 01/24/24 at 11:30 A.M. with Resident #28 revealed an aide came into her room to offer to turn the station on the television. Resident #28 stated she did not get asked to reposition, get out of the chair, or receive incontinence care. Observation revealed Resident #28 sitting in a recliner. Interview and observation at 01/24/24 at 1:56 P.M. with STNA #115 verified Resident #28 had moderate urine saturation in her incontinent brief. STNA #115 stated she provided incontinence care to Resident #28 two to three times that day. Resident #28 stated STNA #115 had only changed her at 7:00 A.M. STNA #115 stated again she had changed her several times that day. Resident #28 again stated she was only changed once today at 7:00 A.M. STNA #115 then changed her mind and stated she does not remember how many times she had changed Resident #28 today. STNA #115 remembered she had only changed Resident #28 once today at 7:00 A.M. and now. Interview on 01/24/24 at 2:59 P.M. with Resident #28 stated it was not respectful when STNA #115 stated she had checked and changed her two to three times today already when it was not true. Resident #28 stated she knew she was only changed at 7:00 A.M. when she had gotten up for the day. Review of facility policy titled, Urinary Continence and Incontinence, Assessment and Management, not dated, revealed the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. A check and change strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin. This deficiency represents non-compliance investigated under Master Complaint Number OH00150176.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Review of facility record, observation, interview, and facility policy, the facility failed to provide supervision when taking medication for one resident (#50) out of four residents reviewed for medication. Facility census was 72. Findings include: Review of the medical record revealed Resident #50 had an admitted [DATE]. Diagnoses included muscle wasting and atrophy, anxiety disorder, depression, glaucoma, and macular degeneration. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #50 was cognitively intact. Observation and interview on 01/22/24 at 11:18 A.M. with Resident #50 in their room with a medication cup with five pills left on the bedside table unattended. Interview on 01/22/24 at 11:22 A.M. with Licensed Practical Nurse (LPN) #56 verified medications were left at Resident #50's bedside table unattended. LPN #56 reported medications left were Miralax in water, one Citalopram 20 milligram (mg), one Buspar 5 mg, one Robaxin 500 mg, and two Gabapentin 100 mg. Review of facility policy titled, Storage of Medications, not dated revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner.