STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366251	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Home at Hearthstone, The	8028 Hamilton Avenue Cincinnati, OH 45231

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 - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, review of the admission agreement, and record review, the facility failed to ensure residents were treated with dignity and respect during dining and incontinence care. This affected four (#6, #27, #38, and #55) of four residents reviewed for dignity. The facility census was 87. Findings include:1. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction.The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 had moderately impaired cognition and required substantial assistance with toileting. Observation in the 100-hallway on 12/17/25 from 9:03 A.M. to 9:05 A.M. revealed staff were performing incontinence care on Resident #6 without the door closed or privacy curtain pulled. From the hallway, staff were observed in Resident #6's room and rolled the resident on her side so that she was uncovered and no clothes from waist down. The staff rolled Resident #6 the other way still undressed. Licensed Practical Nurse (LPN) #22 closed Resident #6's door at 9:06 A.M. Interview on 12/17/25 at 9:06 A.M. with LPN #22 confirmed the door was open while staff were performing incontinence care.Observation and interview on 12/17/25 at 9:09 A.M. revealed Certified Nursing Assistant (CNA) #23 walking out of Resident #6's room with a bag of soiled items. CNA #23 confirmed the door was open during incontinence care for Resident #6. Interview on 12/17/25 at 2:42 P.M. with the Administrator and the Director of Nursing (DON) confirmed the privacy curtain should remain pulled and the door closed during incontinence care. Review of the facility's (undated) admission packet revealed the residents have the right to privacy during medical examination or treatment and in the care of personal or bodily needs.2. Review of the medical record revealed Resident #27 had diagnoses including Alzheimer's disease with early onset, delusional disorders, and dementia. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the Resident #27 had severely cognitive impairment, and required set up assistance for eating.Review of the medical record revealed Resident #38 had diagnoses including vascular dementia, dysphagia, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. The MDS 3.0 assessment dated [DATE] revealed Resident #38 had moderately impaired cognition and was dependent on staff for eating.Review of the medical record revealed Resident #55 had diagnoses including dementia, dysphagia following cerebral infarction, aphasia, and type two diabetes mellitus. The MDS 3.0 assessment dated [DATE] revealed Resident #55 had severe cognitive impairment and required set up assistance for eating.Observation on 12/17/25 at 11:48 A.M. revealed Certified Nursing Assistant (CNA) #99 placed a clothing protector on Resident #55. Resident #55 was in wheelchair at the table in the dining room preparing to eat. CNA #99 then put the clothing protectors on Resident #27 and Resident #38.Interview on 12/17/25 at 11:50 A.M. with CNA #99 revealed clothing protectors were put on the residents in case the residents try to feed themselves, it will prevent food from getting on them. Interview on 12/17/25 at 12:07 P.M. with the Administrator revealed the clothing protectors were used if the residents were care planned for it, but not sure if there was a policy regarding the clothing protectors. At 12:15 P.M., the Administrator confirmed there was no policy for clothing protectors. The Administrator confirmed they wear the clothing protectors if residents request them. The Administrator was unable to answer if clothing protectors should be worn for residents who have severe cognitive impairment. Interview on 12/17/25 at 1:08 P.M. with CNA #76 confirmed they automatically put on clothing protectors to protect clothing, they do not ask residents, and no residents ask for the clothing protectors. Review of the facilities (undated) admission packet revealed the residents have the right to be treated at all times with courtesy, respect, and full recognition of dignity and individuality.This deficiency represents non-compliance investigated under Complaint Number 2645862.