

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Clifton Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 625 Probasco Street Cincinnati, OH 45220	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35770</p> <p>Based on record review, observation, staff interviews, and policy review the facility failed to ensure physician orders were timely clarified to prevent a delay in medication administration. This affected one (#37) resident of the three residents reviewed for medication administration. The facility census was 140.</p> <p>Findings include:</p> <p>Review of Resident #37's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis (MS), tubular interstitial nephritis, diabetes mellitus, morbid obesity, paraplegia, major depressive disorder and retention of urine.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was cognitively intact.</p> <p>Review of the physician order dated 09/06/24 for Resident #37 revealed the resident was ordered Bactrim double strength (DS) (Sulfamethoxazole-Trimethoprim) 800-160 milligrams (mg) (antibiotic) two times a day (8:00 A.M. and 5:00 P.M.) for infection until 09/14/24.</p> <p>Review of a nurse's progress note dated 09/06/24 at 736 P.M. revealed Resident #37 was ordered Bactrim DS for seven days. Review of additional nurse's notes revealed no documentation regarding the resident not receiving the Bactrim on 09/07/24 and 09/08/24.</p> <p>Review of the September 2024 medication administration record (MAR) for Resident #37 revealed on 09/07/24 at 8:00 A.M. and 5:00 P.M. was marked with a 5 indicating hold /see nurses notes On 09/08/24, the 8:00 A.M. dose was recorded as being administered and the 5:00 P.M. was recorded with a 5.</p> <p>Interview via phone on 10/23/24 at 8:19 A.M. with Pharmacy Technician #508 revealed a pharmacist entered a note where he called the facility on 09/06/24 and talked to Registered Nurse (RN) #115 informing her of Resident #37's Bactrim would not be sent to the facility due to the resident's recorded sulfacetamide allergy and the facility needed to call the provider to get clarification. RN #115 noted she would contact the provider and get clarification.</p> <p>(continued on next page)</p>

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview via phone on 10/23/24 at 10:24 A.M. with RN #115 revealed she talked with a pharmacist on 09/06/24 about Resident #37's Bactrim order and she would call the provider and get another medication due to the allergies on file. RN #115 stated she called the on-call provider; however, the provider would not order a new antibiotic.</p> <p>Interview via phone on 10/23/24 at 11:16 A.M. with LPN #101 revealed she did not give the two ordered doses Bactrim to Resident #37 on 09/07/24 due to not being available. LPN #101 stated the facility was awaiting delivery from the pharmacy and then forgot to follow up on the medication orders.</p> <p>Review of the Medication Administration (dated 2013) revealed it is the policy of this facility to provide resident centered care that's meets the psychosocial, physical, and emotional needs and concerns of the residents.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158589.</p>