

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  04/22/2026
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 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure residents had visual privacy in their bedroom. This affected two residents (Resident #15 and #147) of three residents reviewed for the physical environment. The facility census was 137 residents. Findings include: Observation on 04/19/26 at 10:18 A.M. revealed there no privacy curtains were in place in the double occupancy room of Residents #15 and #147. Interview on 04/19/26 at 10:20 A.M. with Medication Technician (MT) #418 verified no privacy curtains were present in the double occupancy room of Residents #15. Review of facility policy titled Resident Rights revealed residents had the right to visual privacy. This deficiency represents noncompliance investigated under Complaint Number 2606421.</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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