STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365304	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Healthcare Center	625 Probasco Street Cincinnati, OH 45220

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, record review, and review of the facility policy, the facility failed to store foods in a sanitary manner and failed to maintain a clean and sanitary kitchen This had the potential to affect 135 of 137 residents who received food from the kitchen. The facility census was 137 residents.Findings include: Observation on 04/19/26 at 8:40 A.M. with Dietary Aide (DA) #853 revealed there were no paper towels available at handwashing station. Observation on 04/01/26 at 8:42 A.M. of stand-up refrigerator revealed it contained the following items: a container of sandwiches with no date, a half-gallon of milk with an expiration of date of 04/09/26, an opened jar of grape jelly with no date, a container of whipped cheese spread with an open date of 03/19/26, a cottage cheese container with use by date of 04/09/26. Interview on 04/01/26 at 8:43 A.M. with DA #853 confirmed there were no paper towels available for staff to use with handwashing, and the stand-up refrigerator contained undated and expired items. Observation on 04/19/26 8:52 A.M of walk-in refrigerator with DA #853 revealed the door would not close properly and the refrigerator contained the following items: an undated metal pan of cooked hamburgers, a large, sealed roll of undated ground beef, four gallons of milk with an expiration date of 04/09/26. Interview on 04/19/26 at 8:52 A.M. with DA #583 confirmed the door to the walk-in refrigerator did not close properly and the refrigerator contained undated and expired items. Observation on 04/19/26 at 9:03 A.M. of walk-in freezer with DA #853 revealed the freezer contained the following items: a large box of undated green peas, a pack of undated veggie burgers open to air, a large box of undated hotdogs in a plastic bag open to air, a large box of undated mixed vegetables in a plastic bag open to air, a box of undated cookie dough balls in a plastic bag open Interview on 04/19/26 at 9:03 A.M. with DA #853 confirmed the walk-in freezer contained undated and open to air items. Observation on 04/19/26 at 9:15 A.M. with DA #853 revealed the exhaust fan above oven was dirty and there were three large metal pans which were still wet from being washed stacked one on top of the other. Interview on 04/19/26 at 9:15 A.M. with DA #853 confirmed the exhaust fan above the oven was dirty and he was unsure of when it was last cleaned and was unsure of who was responsible for cleaning it. DA #853 confirmed the wet metal pans had not been dried before being stacked for storage. Observation on 04/20/26 at 2:45 P.M. with Clinical Director of Dietary Operations (CDDO) #860 P.M. revealed the walk-in refrigerator contained the following items: a container of tuna salad covered with plastic wrap which was ripped and left the tuna salad open to air, a bag of lettuce which was open to air, two containers of opened and undated shredded cheese. The walk-in freezer contained a box of frozen biscuits in an unsealed bag which was open to air, a plastic bag of hamburger patties open to air, a box of turkey patties in an unsealed bag open to air. Interview on 04/20/26 at 2:45 P.M. with CDDO #860 confirmed the undated and open-to-air items in the walk-in refrigerator Observation on 04/20/26 at 3:07 P.M. with CDDO #860 revealed there were two wet trays stacked together stored with other clean and dry pans. Interview on 04/20/26 at 3:07 P.M. with CDDO #860 confirmed the wet trays had not been dried before being stacked for storage. Observation on 04/21/26 at 11:53 A.M. of tray line revealed [NAME] #833 removed a hamburger bun from a bag with her bare hands to place on a resident tray. Interview on 04/21/26 at 11:53 A.M. with CCDO #860 confirmed [NAME] #833 had touched the hamburger bun (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with her bare hands and the bun should be discarded. Interview with administrator on 04/21/26 at 3:35 P.M. revealed that the only resident refrigerators in the facility on nursing units were on the first floor and the third floor. Observation of the first-floor refrigerator revealed a new empty refrigerator that had not been put into service. Observation on 04/21/26 at 3:35 P.M. of the third-floor refrigerator in the conference room used for resident food revealed there was a spill of pink liquid and crumbs and debris throughout the refrigerator. The refrigerator contained the following items: an unlabeled undated container of food, an undated container of shredded cheese, a quart of milk with an expiration date of 08/05/25, a bottle of blue cheese dressing with an expiration date of 10/20/25. Interview on 04/21/26 at 3:35 P.M. with the Administrator confirmed the third-floor refrigerator needed to be cleaned and contained unlabeled, undated, and expired items which should have been discarded. Review of the facility policy titled Food Storage: Cold Foods dated February 2026 revealed all foods would be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on medical record review, staff interview, guardian interview, and review of the facility policy, the facility failed to obtain consent from resident guardians regarding treatment. This affected (Residents #28, #64, #121, and #138) of 27 residents reviewed for consent for treatment. The facility census was 137 residents.Findings include: 1.Review of the medical record for Resident #28 revealed an admission date of 01/27/26 with diagnoses including schizophrenia and type two diabetes. Review of the guardianship form for Resident #28 revealed Resident Guardian (RG) #999 was appointed by the court for the resident on 04/26/24. Review of a consent form for pharmacogenomics testing for Resident #28 dated 11/26/25 revealed RG #999 had not signed the form. Review of the Minimum Data Set (MDS) assessment for Resident #28 dated 01/22/26 revealed the resident had intact cognition. 2. Review of the medical record for Resident #64 revealed an admission date of 11/21/23 with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, diabetes mellitus type two, and vascular dementia. Review of the guardianship form for Resident #64 revealed RG #999 was appointed by the court for the resident on 05/22/24. Review of a consent form for pharmacogenomics testing for Resident #64 dated 09/25/25 revealed RG #999 had not signed the form. Review of the MDS assessment for Resident #64 dated 03/01/26 revealed the resident had intact cognition. 3. Review of the medical record for Resident #121 revealed an admission date of 03/22/24 with diagnoses including osteoarthritis, hypertension, and Alzheimer's disease Review of the guardianship form for Resident #121 revealed RG #999 was appointed by the court for the resident on 09/11/24. Review of a consent form for pharmacogenomics testing for Resident #121 dated 11/03/25 revealed RG #999 had not signed the form. Review of the MDS assessment for Resident #121 dated 03/22/25 revealed the resident had moderate cognitive impairment. 4. Review of the medical record for Resident #138 revealed an admission date of 09/30/01 with diagnoses including schizoaffective disorder, chronic obstructive pulmonary disease, and diabetes mellitus type two. Review of the guardianship form for Resident #138 revealed RG #999 was appointed by the court for the resident on 05/30/07. Review of a consent form for pharmacogenomics testing for Resident #138 dated 09/25/25 revealed RG #999 had not signed the form. Review of the MDS assessment for Resident #138 dated 02/05/26 revealed the resident had severe cognitive impairment. Interview on 04/20/26 at 2:25 P.M with RG #999 confirmed she was the court-appointed guardian for Residents #28, #64, #121, and #138. RG #999 confirmed the facility had not obtained her consent for pharmacogenomics testing for the residents. Interview on 04/21/26 at 7:47 A.M with the Administrator confirmed RG #999 was the court-appointed guardian for Residents #28, #64, #121, and #138. The Administrator confirmed the facility had not obtained the guardian's consent for pharmacogenomics testing for the residents. Review of facility policy titled Consent to Treat revealed the facility should ensure residents' legal representatives are informed of the type of care and services provided within the facility.

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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. Based on medical record review and staff interview, the facility failed to document timely care conferences for residents. This affected four (Residents #79, #1, #15, and #135) of 27 residents sampled. The facility census was 137 residents: Findings include:1. Review of the medical record for Resident #135 revealed an admission date of 03/17/25 with diagnoses including vascular dementia with behavioral disturbance, anxiety, depression, and glaucoma. Review of the Minimum Data Set (MDS) assessment for Resident #135 dated 03/25/26 revealed the resident had severely impaired cognition. Review of the medical record for Resident #135 revealed the facility held care conferences for the resident on 03/18/25 and 04/17/26. Interview on 04/19/26 at 3:10 P.M. with Resident #135's representative confirmed the resident had not had any recent care conferences. Interview on 04/21/26 at 9:47 A.M. with Social Services Designee (SSD) #321 verified the facility held care conferences for Resident #135 on 03/18/25 and 04/18/26. SSD #321 stated care conferences should be held quarterly. 2. Review of medical record for Resident #79 revealed an admission date of 10/14/13 with diagnoses including Alzheimer's disease, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and aphasia. Review of the MDS assessment for Resident #79 dated 02/14/26 revealed the resident was cognitively impaired. Review of the medical record for Resident #79 revealed the facility held care conferences for the resident on 12/24/24, 03/21/25, and 01/23/26. Interview on 04/20/26 at 3:42 P.M. with the Director of Social Services (DSS) #477 confirmed the most recent care conferences for Resident #79 were dated 12/12/24, 03/21/25, and 01/23/26. DSS #477 confirmed no other care conference documentation since 12/12/24 was available for Resident #79, and care conferences should have been held on a quarterly basis. 3. Review of medical record for Resident #1 revealed an admission date of 04/22/25 with diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and multiple sclerosis. Review of the MDS assessment for Resident #1 dated 02/18/26 revealed the resident was cognitively intact. Review of the medical record for Resident #1 revealed the facility held a care conference for the resident on 04/25/25. Interview on 04/21/26 10:18 A.M. with DSS #477 confirmed 04/25/25 was the only documented care conference in Resident #1's record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of medical record for Resident #15 revealed an admission date of 01/16/25 with diagnoses including alcoholic cirrhosis of liver with ascites, type two diabetes mellitus, and hepatic encephalopathy. Review of the MDS assessment for Resident #15 dated 03/09/26 revealed the resident was cognitively intact. Review of the medical record for Resident #15 revealed the facility held a care conference for the resident on 01/25/25. Interview on 04/21/26 at 10:25 A.M. with DSS #477 confirmed the most recent care conference for Resident #15 was held on 01/25/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview, document review, and review of the facility policy, the facility failed to safely store chemicals on the secured unit. This had the potential to affect seven facility-identified independently mobile and cognitively impaired (Residents #16, #30, #48, #75, #79, #115, #130) who resided on the secured unit. The facility census was 137 residents. Findings include: Observation on 04/19/26 at 12:39 P.M. of the first-floor dining room in the secured unit revealed there were two cans of shaving cream in an unlocked drawer. The label on the shaving cream indicated to avoid spraying in eyes and keep out of reach of children. There was also a bottle of body wash and shampoo with a label indicating to avoid contact with eyes and keep out of reach of children. There was a spray bottle of multi-surface disinfectant in an unlocked lower cabinet with a label with the following warning statements: keep out of reach of children, hazardous to humans and domestic animals, cause moderate eye irritation, avoid contact with eyes and clothing, do not drink. Interview on 04/19/26 at 12:50 P.M. with Registered Nurse (RN) #360 confirmed the shaving cream, body wash/shampoo, and disinfectant spray should be stored in a secured location and should not be accessible to residents. Review of a Safety Data Sheet (SDS) for Ecolab Rapid Multi Surface Disinfectant Cleaner revealed it included the following hazard statements: causes severe skin burns and eye damage, harmful if inhaled, if swallowed immediately call a poison center doctor. Review of facility policy titled Care of Chemical Storage Areas dated 02/01/25 revealed staff should lock chemical storage areas or carts when not in use to prevent unauthorized access.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to provide nailcare for dependent residents. This affected two residents (#35 and #64) of three residents reviewed for activities of daily living (ADL) care. The facility census was 137 residents.Findings include: 1.Review of the medical record revealed for Resident #35 revealed an admission date of 07/17/24 with diagnoses including paranoid schizophrenia, vascular dementia, post-traumatic stress disorder and obsessive-compulsive disorder. Review of the care plan for Resident #35 dated 07/17/24 revealed the resident had a self-care deficit and required supervision/touching assistance for personal hygiene. Review of the Minimum Data Set (MDS) assessment for Resident #35 dated 01/26/26 revealed the resident and required staff assistance with personal hygiene. Observation on 04/20/26 at 10:21 A.M. revealed Resident #35's fingernails were long and had an unknown brown substance under the fingernails. Interview on 04/20/26 at 10:21 A.M. with Resident #35 confirmed the resident wanted staff to trim and clean her fingernails. Interview on 04/20/26 at 3:01 P.M. with Licensed Practical Nurse (LPN) #372 verified Resident #35's fingernails were long, had an unknown brown substance under the nails, and the resident needed staff to perform nailcare. 2. Review of the medical record for Resident #64 revealed an admission date of 11/21/23 with diagnoses including cerebrovascular accident, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and diabetes mellitus type two. Review of the care plan for Resident #64 dated 11/22/23 revealed the resident had a self-care deficit and was dependent on staff for assistance with personal hygiene. Review of the MDS assessment for Resident #64 dated 03/01/26 revealed the resident had intact cognition and was dependent on staff assistance with personal hygiene. Observation on 04/20/26 at 10:46 A.M. revealed Resident #64's left hand fingernails to be long and had an unknown brown substance under the nails. Resident #64's left hand and fingers were contracted, and the resident had to manually use her right hand to pry the left-hand fingers back to be able to view. Interview on 04/20/26 at 10:46 A.M. with Resident #64 confirmed the resident wanted staff to trim and clean the fingernails of her left hand. Interview on 04/20/26 at 3:04 P.M. with LPN #372 verified Resident #64's left hand fingernails were long, with an unknown brown substance under the nails, and the resident needed staff to perform nailcare. Review of the facility policy titled Routine Resident Care undated revealed licensed staff would (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitor and assess resident needs. Findings include: 1. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses of paranoid schizophrenia, vascular dementia, post-traumatic stress disorder and obsessive-compulsive disorder. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #35 had moderate cognitive impairment and was frequently incontinent of bowel and bladder. The resident required supervision for eating, oral and personal hygiene and bathing, moderate assistance for toileting, dressing and transfers, and set up assistance for bed mobility. Review of the plan of care for Resident #35 dated 07/17/24 revealed Resident #35 had a self-care deficit and required supervision/touching assistance for personal hygiene. Observation on 04/20/26 at 10:21 A.M. revealed Resident #35's fingernails to be long and with an unknown brown substance under the nails. Interview on 04/20/26 at 10:21 A.M. with Resident #35 revealed the resident wanted her fingernails to be cut and cleaned. Interview on 04/20/26 at 3:01 P.M. with Licensed Practical Nurse #372 verified Resident #35's fingernails were long, with an unknown brown substance under the nails, and in need of nailcare. 2. Review of the medical record revealed Resident #64 was admitted to the facility on [DATE] with diagnoses of cerebrovascular accident with left (non-dominant) side hemiplegia/hemiparesis, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, diabetes mellitus type II, pseudobulbar affect and vascular dementia. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #64 had intact cognition and was always incontinent of bowel and bladder. The resident required supervision for eating and was dependent for oral and personal hygiene, toileting, bathing, dressing, bed mobility and transfers. Review of the plan of care for Resident #64 dated 11/22/23 revealed Resident #64 had a self-care deficit and was dependent for personal hygiene. Observation on 04/20/26 at 10:46 A.M. revealed Resident #64's left hand fingernails to be long and with an unknown brown substance under the nails. The hand and fingers were contracted, and the resident had to manually use her right hand to pry the left-hand fingers back to be able to view. The resident also stated she had a splint for her left hand that the staff never put on her. The resident said the splint was in the bottom drawer of her bedside dresser. Observation revealed the splint in the bottom drawer of the bedside dresser. Interview on 04/20/26 at 10:46 A.M. with Resident #64 revealed the resident wanted her left-hand fingernails to be cut and cleaned and her splint to be applied. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/20/26 at 3:04 P.M. with Licensed Practical Nurse #372 verified Resident #64's left hand fingernails were long, with an unknown brown substance under the nails, and in need of nailcare. Review of the policy titled, Routine Resident Care, undated, revealed licensed staff will include the following services based upon their scope of practice, but not limited to monitoring and assessment of resident needs

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on medical record review, observation, staff interview, resident interview, and review of the facility policy, the facility failed to ensure residents received care and services for management of contractures and decreased range of motion. This affected three (Residents #65, # 41 and #2) of three residents reviewed for range of motion services. The facility census was 137 residents.Findings include: 1. Review of the medical record for Resident #64 revealed an admission date of 11/21/23 with diagnoses including cerebrovascular accident, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and diabetes mellitus type two. Review of the care plan for Resident #64 dated 11/22/23 revealed the resident had a self-care deficit and was dependent on staff for assistance with personal hygiene. On 04/21/26 an intervention was added for the resident to wear left resting hand splint for six to eight hours as tolerated (may use wash cloth if hand splint is not present). Review of occupational therapy (OT) evaluation for Resident #64 dated 04/12/24 to 05/11/24 revealed goals of therapy were for the resident to complete passive range of motion to left upper extremity in all joints with fair positive tolerance to decrease the risk for contractures and assist with pain management, and for the resident to tolerate a left resting hand splint for up to three hours without pain/irritation noted to increase independence with activities of daily living (ADLs). Review of the physician's orders for Resident #64 revealed an order dated 07/23/24 for the resident to wear a left resting hand splint for six to eight hours as tolerated (may use wash cloth if hand splint is not present) every shift. Review of the Minimum Data Set (MDS) assessment for Resident #64 dated 03/01/26 revealed the resident had intact cognition and was dependent on staff assistance with personal hygiene. Review of the Treatment Administration Record (TAR) for Resident #64 dated April 2026 revealed the left hand splint was checked off as applied for 04/20/26. Observation on 04/19/26 at 9:04 A.M. revealed Resident #64 was lying in bed without a splint on her left hand, and the splint was in the resident's bedside dresser drawer. Interview on 04/19/26 at 9:04 A.M. with Resident #64 confirmed the splint for her left hand was in the bottom drawer of the resident's bedside dresser, and the resident would like the splint to be applied. Interview on 04/19/26 at 9:05 A.M. with Licensed Practical Nurse (LPN) #372 confirmed Resident #64's left hand splint was not in place. Observation on 04/20/26 at 11:13 A.M. revealed Resident #64 was up in the wheelchair without a splint on her left hand and the splint remained in the resident's bedside dresser drawer. Interview on 04/20/26 at 11:13 A.M. with Resident #64 confirmed the splint for her left hand was still not in place and remained in the resident's bedside dresser drawer. Observation on 04/20/26 at 12:32 P.M. revealed Resident #64 was in her wheelchair in the dining room, and the left resting hand brace was not in place. LPN #372 placed a rolled-up washcloth in (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #64's left hand. Interview on 04/20/26 at 12:32 P.M. with LPN #372 confirmed Resident #64's left hand splint was not in place. LPN #372 verified the resident's TAR documented the splint as being applied. Interview on 04/21/2026 at 7:32 A.M. with Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Coordinator #425 verified Resident #64's plan of care made no mention of a left hand/wrist contracture and no identified intervention of a left resting hand splint and/or rolled up washcloth in place of the splint. LPN MDS #425 also verified Resident #64 had no contracture diagnosis, and it was the responsibility of the physician to provide the diagnosis. Interview on 04/21/26 at 10:28 A.M. with the Director of Nursing (DON) verified Resident #64 had no diagnosis of contracture in the medical record. Observation on 04/21/26 at 11:35 A.M. revealed Resident #64 was in her wheelchair in the dining room with no splint on her left hand. LPN #328 placed a rolled-up washcloth in the resident's left hand. Interview on 04/21/26 at 11:35 A.M. with LPN #328 verified Resident #64's left resting hand splint was not in place. Observation on 04/22/26 at 8:55 A.M. revealed Resident #64 was lying in bed without a splint on her left hand, and the splint was in the resident's bedside dresser drawer. Interview on 04/22/26 at 8:55 A.M. with Resident #64 confirmed the splint for her left hand was in the bottom drawer of the resident's bedside dresser Interview on 04/22/26 at 8:57 A.M. with LPN #372 verified Resident #64's left hand splint was not in place. 2. Review of the medical record for Resident #41 revealed an admission date of 10/05/21 with diagnoses including bipolar disorder, dementia, peripheral vascular disease, and contracture of right and left hand. Review of the MDS assessment for Resident #41 dated 04/05/26 revealed the resident #41 was cognitively intact and required supervision with activities of daily living. (ADLs) Interview on 04/19/26 at 10:14 A.M with Resident #41 confirmed he had limitations with both of his hands and his left hand was more affected than his right hand. Interview on 04/21/26 at 1:37 P.M. with Unit Manager (UM) #360 confirmed she was unaware of Resident #41's contractures. Interview on 04/21/26 at 4:17 P.M. with Clinical Manager (CM) #325 confirmed she managed the facility's restorative program and the resident has not received restorative services. Interview on 04/22/26 at 2:05 P.M. with Occupational Therapist (OT) #465 confirmed therapy had not treated Resident #41 for contractures. OT #465 confirmed she assessed Resident #41 on 04/22/26 and determined the resident had bilateral contractures of the upper extremities and should be treated (continued on next page)

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	365304	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Healthcare Center	625 Probasco Street Cincinnati, OH 45220

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for them. 3. Review of the medical record for Resident #2 revealed an admission date of 12/16/25 with diagnoses including chronic respiratory failure, contracture of left hand, and functional quadriplegia. Review of the MDS assessment for Resident #2 dated 03/14/26 revealed the resident had moderate cognitive impairment, was dependent on staff for assistance with ADLs, and had mobility impairments on both sides of upper and lower body. Review of the care plan for Resident #2's dated 04/16/26 revealed there were no interventions in place to prevent worsening of the resident's contracted left hand. Observation on 04/21/26 at 12:36 P.M. revealed Resident #2 was lying in bed, and the resident's left hand was visibly contracted. Resident #2 did not have any assistive devices in place to treat or manage the contracture. Interview on 04/21/26 at 12:36 P.M. with LPN #338 confirmed Resident #2's left hand was visibly contracted, and she was not aware of any interventions to treat or manage the contracture. Interview on 4/21/26 at 1:46 P.M. with Registered Nurse (RN) #374 confirmed Resident #2's left hand was visibly contracted and the facility had not implemented interventions to treat and manage the contracture and prevent it from worsening. Review of facility policy titled Plan of Care Overview undated revealed members of the care planning team would coordinate care to meet the resident's care needs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure staff donned appropriate personal protective equipment (PPE) for residents with orders for contact precautions. This affected two residents (Resident #77 and #131) of seven residents reviewed for infection control. The facility also failed to ensure staff practiced appropriate hand hygiene during incontinence care. This affected one resident (Resident #123) of seven residents reviewed for infection control. The facility census was 137 residents. Findings include: 1.Review of the medical record for Resident #77 revealed an admission date of 06/13/22 with diagnoses including hypertensive heart disease, chronic kidney disease, and type two diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #77 dated 04/12/26 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #77 revealed an order dated 04/13/26 for the resident to be on contact isolation until 04/20/26 related to an escherichia coli (e-coli) infection. Review of the care plan for Resident #77 dated 04/19/26 revealed the resident had a urinary tract infection (UTI). Interventions included the resident should be maintained on contact precautions. Observation on 04/19/26 at 12:40 P.M. revealed the door to Resident #77's room displayed a sign indicating the resident was contact precautions and staff should don a gown and gloves before entering the room. There was a storage unit outside Resident #77's door which contained gowns and gloves. Observation on 04/19/26 at 1:06 P.M. revealed Certified Nursing Assistant (CNA) #309 entered Resident #77's room and removed Resident #77's lunch tray without donning a gown and gloves prior to entering the room. Interview on 04/19/26 at 1:06 P.M. with CNA #309 verified she did not don a gown and gloves before entering Resident #77's room. CNA #309 further verified the door to Resident #77's room had a sign to indicate the resident was under contact precautions. 2. Review of the medical record for Resident #131 revealed admission date of 8/28/25 with diagnoses including spinal stenosis, major depressive disorder, and chronic kidney disease stage two. Review of the MDS assessment for Resident #131 dated 3/12/26 revealed the resident was cognitively intact and required staff assistance with ADLs. Review of the physician's orders for Resident #131 revealed an order dated 04/22/26 for contact precautions due to e an e coli infection in the urine. Observation on 4/21/26 at 8:18 A.M. revealed CNA #430 entered Resident #131's room to provide personal hygiene care and did not don a gown and gloves prior to entering the room. There was a sign on Resident #131's door indicating all care providers should don gloves and a gown before entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/21/26 at 8:26 A.M. with CNA #430 confirmed he had not donned a gown and gloves prior to entering Resident #131's room to provide care. Interview on 04/21/26 at 10:36 A.M. with the Director of Nursing (DON) verified staff should don a gown and gloves before entering the room of a resident on contact precautions. Review of the facility policy titled Standard Precautions and Transmission-Based Precautions dated 07/22/19 revealed staff should don a gown and gloves prior to contact with a resident or the resident's environment for residents under contact precautions. 3. Review of the medical record for Resident #123 revealed an admission date of 03/08/22 with diagnoses including schizoaffective disorder, chronic viral hepatitis C, and history of methicillin resistant staphylococcus aureus infection. Review of the MDS assessment for Resident #123 dated 01/29/26 revealed the resident had intact cognition and was dependent on staff for ADL care. Observation on 04/22/26 at 9:07 A.M. of incontinence care for Resident #123 per CNA #444 revealed the aide placed clean washcloths in the bathroom sink and then washed her hands over the sink. CNA #444 placed the wet washcloths on the bedside table and donned clean gloves. CNA #444 removed the resident's soiled brief and provided incontinence care. During incontinence care CNA #444 placed additional washcloths in the sink, grabbed the bottle of soap, and turned on the faucet while still wearing the soiled gloves. CNA #444 then turned off the faucet and continued incontinence care. Interview on 04/22/26 at 9:21 A.M with CNA #444 confirmed they placed clean washcloths in Resident #123's bathroom sink and washed their hands over the sink. CNA #444 confirmed when her gloves became soiled she did not remove them and perform hand hygiene before continuing with care. Interview on 04/22/26 at 9:30 A.M with the DON confirmed staff should remove gloves and perform hand hygiene when gloves become soiled.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. 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.