STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365551	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clovernook Health Care and Rehabilitation Center	7025 Clovernook 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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 43062 Based on observation, staff interview and review of employee personnel file, the facility failed to ensure the activities program was directed by a qualified professional. This had the potential to affect all 116 residents who resided at the facility. Findings include: Review of the Admissions Director (AD) #132's personnel file revealed AD #132 was hired as the Activity Director on 11/24/15. AD #132's personnel file had no resume with work experience and no Activity Director certificate. Interview with the Human Resource Manager (HRM) #182 on 01/29/25 at 4:40 P.M. verified the facility did not have verification of AD #132's past work experience and AD #132 did not meet the qualifications of an Activity Director. Interview the Administrator on 02/04/25 at 3:00 P.M. verified AD #132 was not a qualified Activity Director.

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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review, review of facility policy, staff interview, hospital social worker interview, dialysis staff interview, review of a a job description for a social worker, and review of facility policy, the facility failed to ensure a resident received hemodialysis as ordered by not assisting and coordinating transportation. This affected one Resident (#117) of the two residents reviewed for dialysis. The facility also failed to ensure active and ongoing communication between the facility and the dialysis center was maintained. This affected one Residents (#05) of the two reviewed for receiving dialysis. The facility census was 116. Findings include: Review of the medical record for Resident #117 revealed the resident was admitted to the facility on [DATE]. Resident #117 discharged with a return anticipated (DRA) to the hospital on 12/31/24 at 1:00 A.M. Diagnoses included end stage renal disease (ESRD), heart failure, dysphagia, and dementia. Review of the physician orders for Resident #117 dated 11/29/24, revealed the resident was ordered hemodialysis treatments on Monday, Wednesday and Saturday. Pick up time was 9:30 A.M and returned to facility around 430 P.M. for two days. Review of a Medication Administration Record (MAR) note for Resident #117 dated 12/26/24 at 12:56 P.M., revealed the resident did not go to dialysis because transportation was canceled. Review of a progress note for Resident #117 dated 12/28/24 at 11:29 A.M., revealed the resident was not picked up by the transportation company for dialysis. A message was left for the on-call physician. Review of a progress note for Resident #117 dated 12/30/24 at 2:14 P.M., revealed the resident's daughter was contacted to let her know the resident was going out non-emergently to the hospital for an evaluation due to missing dialysis. Review of a Change of Condition Situation Background Assessment Recommendation (SBAR) note for Resident #117 dated 12/30/24 at 5:00 P.M., revealed the resident had not been dialyzed in three days. The resident was complaining of stomach pain and not feeling well. The vital signs were obtained, and a call was placed to the ambulance transportation company with a pick-up at 12:00 A.M. Review of a progress note for Resident #117 dated 12/30/24 at 5:00 P.M., revealed the resident was sent out to the hospital to be dialyzed due to not having dialysis in three days per the Director of Nursing (DON). A report was given to the next nurse. The resident was picked up at 1:00 A.M. and transferred to the hospital for dialysis. Review of a progress note for Resident #117 dated 12/31/24 at 7:33 A.M., recorded as a late entry, revealed the resident was being admitted to the hospital for pneumonia and the clinical team was made aware. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note for Resident #117 dated 12/31/24 at 7:40 A.M., revealed the resident was taken to the hospital by ambulance at 1:00 A.M. for dialysis. A nurse-to-nurse report was completed. Review of the hospital medical record revealed Resident #117 was admitted to the emergency room (ER) on 12/31/24 with past medical history of ESRD dependent on hemodialysis and initially presented with confusion. The nursing home was contacted and indicated the resident had a baseline of being alert to self due to history of dementia. The resident missed an unknown amount of dialysis treatments and presented with an elevated Blood Urea Nitrogen (BUN) (a blood test to measure the amount of urea nitrogen in the blood [waste product produced by the liver when protein is broken down which is filtered by the kidneys and excreted through urine]) of 202 milligrams per deciliter (mg/dL) on admission and pneumonia. Antibiotics were started then discontinued due to low suspicions for infection. The family was contacted numerous times without success. The resident was admitted to the hospital on 12/31/24 at 6:08 A.M. with diagnosis of Azotemia (elevated levels of urea and other nitrogen in the blood) due to elevated BUN and mild hyponatremia (low levels of sodium). The renal team was consulted and recommended multiple rounds of hemodialysis. The resident's BUN improved from 202 mg/dL to 78 mg/dL and the resident had no issues with the sessions. The resident's hemodialysis will continue on Tuesday, Thursdays and Saturdays. on 01/02/25 at 10:28 A.M., the hospital's Social Worker (SW) #506 attempted to contact the facility and was unable to speak to Resident #117's nurse after multiple attempts. On 01/06/25 at 3:12 P.M., the resident was discharged to another nursing home where they completed hemodialysis in house. Review of the Minimum Data Set (MDS) assessment for Resident #117, dated 12/31/24, revealed the resident had impaired cognition. Interview with the Dialysis Center Registered Nurse (RN) #500 on 01/28/25 at 9:39 A.M., Resident 117 was a no show for his dialysis treatments on 12/26/24, 12/28/24, and 12/30/24. RN #500 stated she tried to contact the facility and was unable to reach anyone at the facility and the facility would not return any calls. Interview with the facility's Nurse Practitioner (NP) #502 on 01/28/25 at 10:55 A.M. revealed she was made aware Resident #117 had missed his dialysis treatments over the weekend. NP #502 indicated she assessed the resident on 12/30/24 but failed to document her assessment in Resident #502's medical record. NP #502 stated she remembered Resident #117 appeared to be stable and his vitals were within normal limits. NP #502 stated she did remember Resident #117 had some swelling related to the missed dialysis. NP #502 stated she instructed the staff to send the Resident #117 to the hospital non-emergently due to the resident being stable. NP #502 stated she was aware Resident #117 missed two dialysis appointments on 12/26/24 and 12/28/24. NP #502 stated she was aware of the Level of Need Assessment Form-Ambulance Stretcher document needing signed for resident's transportation needs, but stated she wasn't able to sign it due to needing to be signed by a physician. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Admissions Director (AD) #190 on 01/28/25 at 9:50 A.M., revealed she found the Level of Need Assessment Form-Ambulance Stretcher document lying on her desk. AD# 190 stated she also received a call on an unknown date from the ambulance transport company stating they were waiting for the form to be signed by the doctor and returned to them for transport to and from the dialysis center. AP #190 report she had the physician sign the form on 12/29/24 and returned it to the transport company. AD #190 stated she was not certain who was tasked with completing the ambulance stretcher form for residents. Interview with the Director of Nursing (DON) on 01/28/25 at 11:07 A.M., verified Resident #117 missed hemodialysis treatments on 12/26/24, 12/28/24, and 12/30/24 related to not having transportation set up. The DON stated she asked NP #502 to assess Resident #117 on 12/30/24 related to the resident missing his hemodialysis treatments. The DON stated the resident was transported to theER on [DATE] at 1:00 A.M. non-emergently for an evaluation from not receiving hemodialysis and was admitted for hyponatremia. The DON stated she spoke with Resident #117's family member when the resident was sent to the ER and learned Resident #117's daughter was not happy with his care at the facility. The DON stated Resident #117's daughter planned to transfer Resident #117 to another facility where his needs could be met. Interview with the Administrator on 01/28/25 at 12:34 P.M., revealed the family wasn't happy with Resident #117's care when the DON spoke to the family. The Administrator indicated this should have set off some type of concerns where the facility was not meeting Resident #117's needs. The Administrator verified the facility staff did not assist in setting up transportation to and from dialysis which caused the resident to miss his dialysis appointment on 12/26/24, 12/28/24 and 12/30/24. Subsequent interview with the Administrator on 01/29/25 at 11:13 A.M., revealed the social worker was tasked with arranging the residents' transportation. The Administrator stated the facility has not had a social worker since 12/19/24. Interview with the Medical Director (MD) #525 on 01/29/25 at 11:38 A.M., revealed he was aware Resident #117 missed hemodialysis treatments on 12/26/24 and 12/28/24. MD #525 stated NP #502 was aware Resident #117 had missed hemodialysis treatments on 12/30/25 due to assessing the resident on this date. MD #525 stated he was not aware the missed hemodialysis treatments were related to the facility's failure to set up transportation for Resident #117. Interview with an Ambulance Transport Representative #600 on 02/10/25 at 12:30 P.M., revealed Resident #117 had notes for transport to the dialysis center on 12/26/24 and 12/28/24; however, they were canceled on 12/30/24. Ambulance Transport Representative #600 stated no drivers were assigned to the transports on 12/26/24 and 12/28/24 but there weren't any notes as to why the transports weren't completed. Ambulance Transport Representative #600 stated the Level of Need Assessment Form-Ambulance Stretcher was good for one year from the date of the provider's signature and there was only an unsigned temporary form on file for Resident #177 from the previous week. Ambulance Transport Representative #600 indicated if the form wasn't signed by a provider, then they wouldn't be able to do the transport. Review of the facility policy titled, Transportation Dialysis, dated December 2008, confirmed the facility will assist with arrangement of transportation to and from dialysis. The facility is responsible for the arrangement and suitable transport of the dialysis patient to and from the dialysis unit. This includes the mode of transportation. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of undated job description for the Social Worker revealed the social worker will assist in arranging transportation to other facilities when necessary. 2. Review of the medical record for Resident #05 revealed the resident was admitted to the facility on [DATE]. Diagnoses included ESRD, heart failure, orthostatic hypotension, vascular dementia, dm, and major depressive disorder. Review of the medical record for Resident #05 from 11/01/24 to 01/29/25 revealed no documented evidence of any ongoing communication between the dialysis center and the facility. Review of the MDS assessment dated [DATE], revealed Resident #05 had impaired cognition. Review of the physician orders for Resident #05 dated 05/16/23 revealed for staff complete a dialysis communication sheet with assessment and vital signs prior to going to dialysis on Tuesday, Thursday, and Saturday. An additional order dated 05/16/23 revealed ensure Resident #05 returns from dialysis with a completed communication form and if the form doesn't return with the resident, request the form to be faxed over and file in chart. Interview with the DON on 01/29/25 at 10:17 A.M., verified the facility had no documented evidence of any communication forms between the dialysis center and the facility for Resident #05. Review of the facility policy titled, End State Renal Disease-Care for Residents dated 2001, confirmed the facility staff will have education and training on the type of assessment data that is to be gathered about the resident's condition on a daily per shift basis to be exchanged between the facilities. This deficiency represents non-compliance investigated under Complaint Number OH00161189.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 43062 Based on record review, observation, and staff interview, the failed to ensure employment of a full-time, qualified social worker. This had the potential to affect all 116 residents who resided at the facility. Findings include: Review of the employee file for the most recent Social Worker #575, revealed a hire date of 09/18/24 and a termination date of 12/19/24. Interview with the Administrator on 01/29/25 at 11:13 A.M., verified the facility did not have a qualified social worker available for the residents. The Administrator stated she thought her facility was only licensed for 119 beds.