

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Clovernook Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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, and review of the facility policy, the facility failed to store food in a safe and sanitary manner. This had the potential to affect all 115 facility-identified residents who received food from the kitchen. The facility census was 119 residents. Findings include: 1. Observation on 04/06/26 at 8:25 A.M. of the kitchen with Diet Manager (DM) #600 revealed following concerns: - The walk-in refrigerator contained the following items: two pans of uncovered prepared foods with no date or label, four wrapped sandwiches undated, a bag of boiled eggs with no open date, an opened container of cottage cheese with a use by date of 04/01/26, a bag of opened undated cheese, a bag of opened and undated lettuce. - There were no paper towels available at the handwashing sink - The reach in refrigerator contained two containers of unidentifiable foods with no label and no dates. - The dry storage area contained the following items: opened and undated bags of pasta, cake mix, potato chips, cheesecake mix, and frosting mix, multiple cans of food with no received date. Interview on 04/06/26 at 9:30 A.M. with DM #600 verified the unlabeled, undated and expired foods and stated they should have been discarded. DM #600 confirmed there should have been paper towels at the handwashing sink, and cans of food should be dated upon receipt. Review of facility policy titled Food Receiving and Storage dated 2017 revealed foods will be covered, labeled and dated, and used within seven days of preparation date. Dry foods will be dated and rotated. 2. Review of food temperature logs dated March 2026 and April 2026 revealed there were no temperatures logged for breakfast, lunch or supper food on the following dates: 03/29/26, 03/30/26, 03/31/26, 04/03/26, and there were no food temperatures logged for supper on the following dates: 04/01/26, 04/02/26, 04/04/26, 04/05/26. Interview on 04/06/26 at 9:35 A.M. with DM #600 confirmed missing temperature logs for March and April 2026, and stated kitchen staff are supposed to log food temperatures at every meal. 3. Observation on 04/08/26 at 10:30 A.M. with DM #600 revealed the following concerns in the kitchen. - During the preparation of the pureed foods [NAME] # 601 reassembled a clean puree blender bowl blade using gloves that had touched the food counter and multiple other items in the dish machine area. (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There were six ceiling vents located over the food preparation area with visible blackened fuzzy debris and one vent that had no covering. -There were no testing strips available to test the chemical used in the sanitizing solution in the dish washing area. -There were no logs of testing of the sanitizer bucket solutions for the months of February, March, and April 2026. -The dishwasher temperature gauges had condensation inside the gauges such that the temperature could not be read. Interview on 04/09/26 at 10:30 A.M. with DM #600 verified [NAME] #601 should have sanitized her hands prior to reassembling the food processor and the ceiling vents should be clean and covered. DM #600 verified the dishwasher gauges could not be read for temperature monitoring due to the condensation inside the gauges and the sanitizing solution buckets had not been tested for three months, because the correct testing strips were not available. Review of facility policy titled Food Preparation and Service dated 2017 revealed staff will adhere to sanitary practices to prevent spread the foodborne illness. Review of facility policy titled Dishwashing Machine Use dated 2010 revealed the dish machine operator will check the dish machine temperature using the machine gauge with each dish machine cycle and will record in the log.		

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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. Based on review of personnel records and staff interview, the facility failed to employ a full-time qualified Licensed Social Worker (LSW). This had the potential to affect all of the residents residing in the facility. The facility census was 119 residents. Findings include: Review of the employee file for Social Service Worker (SSW) #175 revealed a hire date of 02/26/25 as a Certified Nursing Assistant (CNA). On 10/27/25 the facility promoted the CNA to her current position as SSW. Further review of SSW #175's employee file revealed the SSW was not a licensed social worker. Interview on 04/08/2026 at 3:23 P.M, with the Administrator confirmed the facility was licensed for 126 Medicare/Medicaid beds and was required to have a full-time qualified LSW working at the facility. The Administrator confirmed SSW #175 was not an LSW and the facility did not have an LSW employed with them.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, staff interview, and review of the facility policy, the facility failed to ensure nursing staff followed proper hand hygiene protocols. This had the potential to affect all of the residents residing in the facility. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to implement enhanced barrier precautions for one (Resident #23) of 40 residents with orders for EBP. The facility census was 119 residents. Findings include: 1. Observation on 04/06/26 at 8:15 A.M. revealed Unit Manager (UM) #400 had long multicolored artificial fingers nails with raised decorations on each of her fingers which extended beyond the tips of her fingernails. Interview on 04/06/26 at 8:15 A.M. with Unit Manger #400 confirmed she had opaquely painted artificial fingernails that extended beyond the tips of her fingers. Observation on 04/08/26 at 8:30 A.M. revealed Licensed Practical Nurse (LPN) #404 had long opaque yellow artificial fingernails. Interview on 04/08/2026 at 8:30 A.M. with LPN #404 confirmed she had painted artificial fingernails that extended beyond the tips of her fingers. Review of the facility policy titled Handwashing/Hand Hygiene dated October 2023 revealed personnel with direct resident care responsibilities should maintain short, natural fingernails and fingernails should not extend past the fingertips. Wearing artificial fingernails was strongly discouraged among staff members with direct resident-care responsibilities and was prohibited among those caring for severely ill or immuno-compromised residents. 2. Review of the medical record for Resident #23 revealed an admission date of 01/24/26 with diagnoses including chronic kidney disease, diabetes mellitus (DM), and vascular dementia. Review of the physician's orders for Resident #23 revealed an order dated 01/24/26 for outpatient dialysis on Tuesday and Saturday. Review of the care plan for Resident #23 updated 04/06/26 revealed the resident had a physician's order for EBP. Interventions included the following: direct staff and visitors to follow EBP, direct staff to utilize gowns and gloves for all personal care, educate direct care staff and visitors on EBP. Review of the physician's orders for Resident #23 revealed an order dated 04/06/26 for EBP related to dialysis access and wounds. Review of the Minimum Data Set (MDS) assessment for Resident #23 dated 04/07/26 revealed the resident had severely impaired cognition and was dependent on staff for activities of daily living (ADLs.) Observation on 04/06/26 at 3:14 P.M. revealed Resident #23's room did not have an EBP sign posted and no personal protective equipment (PPE) was available outside the resident's room. Interview on 04/06/26 at 3:14 P.M. with Registered Nurse (RN) #1002 confirmed Resident #23 required EBP related to his need for dialysis and open wounds. RN #1002 confirmed Resident #23 did not have the required posted signs and did not have PPE outside the room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on interview 04/06/26 at 11:22 A.M with the Infection Control Prevention (ICP) Nurse #305 confirmed the facility failed to properly implement EBP for Resident #23, because there were no signs regarding EBP or PPE outside the resident's door. ICP Nurse #305 confirmed the facility did not obtain the order for EBP precautions for Resident #23 until 04/06/26. Review of the facility policy titled Enhanced Barrier Precautions revised August 2022 revealed EBP should be utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. EBPs were indicated when contact precautions did not otherwise apply for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. EBPs remained in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that placed them at increased risk.		

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Put firmly secured handrails on each side of hallways. Based on observation and staff interview, the facility failed ensure corridors were equipped with handrails on each side. This could potentially affect all 119 residents residing in the facility. The facility census was 119. Findings include: Observation on 04/08/26 at approximately 9:59 A.M. noted that emergency electrical equipment, including transfer switches, manual disconnect switches, and emergency electrical panels, in the egress corridor was not guarded against accidental contact. The facility recently installed a new generator with two transfer switches, manual override switches, and electrical panels in the egress corridor on the first floor that leads to the resident outdoor picnic and smoking areas. This electrical equipment was mounted on the wall with fire-rated lumber behind it. There were no guards on the side facing the egress corridor. Further observation revealed no handrails on the side of the corridor where the equipment was installed. Residents were observed using this corridor, some accompanied and others unaccompanied by staff, to access the smoking area and outdoor picnic area. These findings were verified by the Regional Director of Operations and the Maintenance Director at the time of discovery.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident interview, staff interview, and policy review the facility failed to provide a safe and clean environment for two Residents (#67 and #102) out of three Residents reviewed. The facility census was 119. 1) Review of the medical record for Resident #67 revealed an admission date of 12/01/25. Diagnoses included constipation, insomnia, vitamin-d deficiency, and spinal stenosis. Review of the Minimum Data Set (MDS) dated [DATE] for Resident #67 revealed he was cognitively intact. Review of the Interdisciplinary Team (IDT) Post Fall/Incident Investigation/Summary dated 02/18/26 at 3:30 P.M., revealed Registered Nurse (RN) #858 was notified by Certified Nursing Assistants (CNA) (#1001 and #511) that Resident #67 fell in the shower room. RN #858 noted Resident #67 leaned forward and fell out of the shower chair when it was being maneuvered over a short hump in the floor. Resident #67 complained of pain at level 10 (zero to 10 with zero being no pain and 10 being severe pain). RN #858 notified Nurse Practitioner (NP) #925 and she ordered a stat (immediate) spinal Xray related to fall and pain. The contributing environmental factor for the fall was uneven flooring in the shower room and instability while crossing the uneven area. The root cause was failure to maintain resident stability and positioning during transport in the shower chair, particularly while maneuvering over a floor elevation. The intervention was to educate staff to use reclining shower chair for Resident #67's showers. During an interview on 04/06/26 at 9:50 A.M., Resident #67 stated he had a fall in the shower room. Resident #67 stated he tried to tell the CNA#1001 that she had to pull him backwards in the shower chair in order to get the shower chair over the hump in the floor or he would fall forward. Resident #67 stated CNA #1001 pushed the shower chair in forward motion over the hump causing him to fall onto the floor. Observation of the 300-Hallway shower room floor on 04/06/26 at 10:51 A.M. with CNA #590, revealed the shower floor had a hump near the shower stall entrance and chipped and missing tiles on the shower floor. CNA #590 verified the shower room had an elevated hump near the shower stall entrance. CNA #590 stated the staff had to pull residents backwards in the shower chair over the hump in the floor or the residents would fall forward. During an interview on 04/08/26 at 12:45 P.M., LPN #400 verified Resident #67 fell from the shower chair on 02/18/26 when being pushed into the shower because the floor near the shower staff was buckled and uneven. LPN #400 stated the fall intervention was to use the reclining shower chair. LPN #400 stated staff should have pulled resident backwards across the hump in the floor verses pushing the resident forward. LPN #400 confirmed the chipped and missing tiles on the shower floor. During an interview on 04/08/2026 4:45 P.M., Maintenance Supervisor (MS) #200 verified the third-floor shower room had chipped and missing tile and an area where it was elevated due to floor being buckled. MS #200 stated he was not aware of a resident being injured in the shower room related to the floor being unlevel. During an interview on 04/09/26 at 11:42 A.M., CNA #511 stated she was with Resident #67 in the 300-Hall shower when he fell. CNA #511 stated she walked into the shower room and CNA #1001 was already in the shower room with Resident #67 and had him facing towards the shower stall when he should have been turned around backwards. CNA #511 verified Resident #67 was pushed forward over the hump causing him to fall out of the chair. CAN #511 stated residents had to be pulled backwards across the hump buckle or they could fall. Review of the fall policy titled, Assessing Falls and Their Causes, dated October 2010, confirmed the facility has procedures to provide guidelines for assessing a resident after a fall and to assist staff in identifying the cause of a fall. The facility will identify appropriate interventions taken to prevent future falls. 2) Review of the medical record for Resident #102 revealed an admission date of 02/23/19. Diagnoses included hemiplegia and hemiparesis, cerebral infarction, diabetes mellitus (DM), peripheral vascular disease, major depressive disorder, atherosclerotic heart disease, mood disorder, hypertensive heart disease, and insomnia. Review of the MDS assessment for Resident #102 dated (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/24/26, revealed the resident was cognitively intact. Observation of Resident #102's room on 04/06/26 at 12:58 P.M. with the Director of Nursing (DON), revealed the resident's bed sheet was heavily soiled with dried red and brown substances all over. Resident #102's floor was heavily soiled with dirt, debris and food crumbs scattered throughout the floor. Interview with the DON at the same time verified the conditions of Resident #102's room. Review of the facility policy titled, Quality of Life-Homelike Environment, revised May 2017, revealed Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. This deficiency represents non-compliance investigated under Complaint Numbers 2806245, 2681920, 2672061 and 2649168.		

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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, resident interview, staff interview, and review of the facility policy, the facility failed to provide regular care conferences for the resident and/or resident representative. This affected four (Residents #18, #29, #55, and #142) of four residents reviewed for care conferences. The facility census was 119 residents. Findings include: 1. Review of the medical record for Resident #18 revealed an admission date of 04/27/23 with diagnoses including cerebral infarction, end stage renal disease (ESRD), and chronic congestive heart failure. Review of the social services progress note dated 03/10/26 revealed Resident #18 and the resident's family had a care conference to discuss missing items. Review of the medical record for Resident #18 revealed there were no other documented care conferences for the resident. Interview on 04/08/26 at 5:20 P.M. with the Administrator confirmed there was no supporting documentation, physical or electronic, to verify the facility had conducted regular care conferences for Resident #18. 2. Review of the medical record for Resident #29 revealed an admission date of 12/15/23 with diagnoses including ESRD and dependence on dialysis. Review of the care conference log for Resident #29 revealed the resident had two care conferences in 2024 on 01/25/24 and 10/11/24 with no care conferences for the second and fourth quarters. There were no care conferences held in 2025. Interview on 04/09/26 at 11:30 A.M. with Resident #29 confirmed he had not received regular care conferences to discuss his request to return home. Interview on 04/09/26 at 12:35 P.M. the Administrator verified the Resident #29 should have had care conference quarterly each year. 3. Review of the medical record for Resident #142 revealed an admission date of 09/16/25 with diagnoses including acute respiratory failure, Alzheimer's Disease, and heart disease. Review of the medical record for Resident #142 revealed there was no documentation of an initial care conference for the resident and/or resident representative. Interview on 04/08/26 at 5:20 P.M. with the Administrator confirmed there was no supporting documentation, physical or electronic, to verify the facility conducted an initial care conference for Resident #142. 4. Review of the medical record for Resident #55 revealed an admission date of 04/24/25 with diagnoses including schizoaffective disorder, alcohol abuse, and anoxic brain damage. Review of the medical record for Resident #55 revealed the facility had not conducted quarterly care conferences for the resident and/or resident representative for the third and fourth quarters of 2025. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/08/26 at 5:20 P.M. with the Administrator confirmed there was no supporting documentation, physical or electronic, to verify the facility conducted care conferences for the third and fourth quarter of 2025 for Resident #55. Review of the facility policy titled Resident Participation-Assessment/Care Plans dated February 2021 revealed the resident and his or her representative were encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan. The facility would invite the resident and/or the resident's representative to the care conference with a seven-day advance notice. This deficiency represents noncompliance investigated under Complaint Number 2669472 and Complaint Number 2649168.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to provide nail care and personal care for dependent residents. This affected five (#42, #57, #76, #92 and #107) of six residents reviewed for activities of daily living (ADL) care. The facility census was 119 residents. Findings include: 1. Review of the medical record for Resident #42 revealed an admission date of 10/31/24 with diagnoses including cirrhosis of liver and diabetes mellitus type two. Review of the Minimum Data Set (MDS) assessment for Resident #42 dated 02/03/26 revealed the resident #42 had intact cognition and required maximal assistance with personal hygiene. Review of the care plan for Resident #42 dated 11/21/24 revealed the resident was at risk for skin integrity impairment with an intervention to avoid scratching and keep hands and body parts from excessive moisture and keep fingernails short. Observation on 04/06/26 at 10:30 A.M. revealed Resident #42's fingernails were long and jagged with an unknown brown substance under the nails. Interview on 04/06/26 at 10:30 A.M. with Resident #42 confirmed he would like his fingernails cut and cleaned but required staff assistance to do so. Interview on 04/06/26 at 10:34 A.M. with Certified Nursing Assistant (CNA) #551 verified Resident #42 needed her fingernails cut and cleaned. 2. Review of the medical record for Resident #57 revealed an admission date of 09/25/24 with diagnoses including cerebral infarction with right (dominant) side hemiplegia/hemiparesis and chronic kidney disease. Review of the MDS assessment for Resident #57 dated 12/30/25 revealed Resident #57 had intact cognition and was dependent on staff for personal hygiene. Review of the care plan for Resident #57 dated 10/15/24 revealed the resident had a self-care deficit and required maximal assistance with personal hygiene. Observation on 04/06/26 at 10:42 A.M. revealed Resident #57's fingernails were long and jagged with an unknown brown substance under the nails. Interview on 04/06/26 at 10:42 A.M. with Resident #57 confirmed he would like his fingernails cut and cleaned but required staff assistance to do so. Interview on 04/06/26 at 10:46 A.M. with CAN #514 verified Resident #57 needed his fingernails cut and cleaned. 3. Review of the medical record for Resident #76 revealed an admission date of 01/06/23 with diagnoses including traumatic brain injury and chronic kidney disease. Review of the MDS assessment for Resident #76 dated 01/08/26 revealed the resident had severe cognitive impairment and resident required moderate assistance with personal hygiene. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan for Resident #76 dated 01/10/23 revealed the resident had a self-care deficit and required moderate assistance with personal hygiene. Observation on 04/06/26 at 10:52 A.M. revealed Resident #76's fingernails were long and jagged with an unknown brown substance under the nails. Interview on 04/06/26 at 10:52 A.M. with Licensed Practical Nurse (LPN) #410 verified Resident #76's fingernails needed to be cut and cleaned. 4. Review of the medical record for Resident #92 revealed an admission date of 12/11/12 with diagnoses including cerebrovascular accident with hemiplegia/hemiparesis, peripheral vascular disease and bilateral below the knee amputations. Review of the MDS assessment for dated 02/03/26 revealed the resident #92 had moderate cognitive impairment and was dependent for personal hygiene. Review of the care plan for Resident #92 dated 03/19/21 revealed the resident had a self-care deficit with an intervention to check nail length and trim and clean on bath day and as necessary. Observation on 04/06/26 at 10:56 A.M. revealed Resident #92's fingernails were long and jagged with an unknown brown substance under the nails. Interview on 04/06/26 at 10:58 A.M. with Resident #92 confirmed he would like his nails to be cut and cleaned but required staff assistance to do so. Interview on 04/06/26 at 10:59 A.M. with CNA #551 verified Resident #76's fingernails needed to be cut and cleaned. 5. Review of the medical record for Resident #102 revealed an admission date of 02/23/19 with diagnoses including hemiplegia and hemiparesis, cerebral infarction, and diabetes mellitus. Review of the MDS assessment for Resident #102 dated 02/24/26 revealed the resident was cognitively intact and required staff assistance with bathing, dressing, and personal hygiene. Interview on 04/06/26 at 12:45 P.M. with Resident #102 confirmed she had not had a shower and had been in bed since she had her breakfast. Resident #102 confirmed she had asked Certified Nursing Assistant (CNA) #514 several times to get up and get dressed, because she wanted to get up by 2:00 P.M. to get money from her resident account. Observation on 04/06/26 at 12:58 P.M. revealed the Director of Nursing (DON) removed pieces of egg from Resident #102's hospital gown. Interview on 04/06/26 at 12:58 P.M. with the DON confirmed Resident #102 was lying in bed at lunch time wearing a hospital gown which still had pieces of food on it from breakfast. Interview on 04/06/26 at 4:30 P.M. with Resident #102 confirmed CNA #514 had not gotten her out of bed and dressed until after 2:00 P.M. Interview on 04/06/26 at 4:34 P.M. with CNA #514 confirmed it was after 2:00 P.M. before the aide had (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Clovernook Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7025 Clovernook Avenue Cincinnati, OH 45231	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a chance to clean and dress Resident #102. Observation on 04/07/26 at 9:05 A.M. revealed Resident #102 was lying in bed wearing a hospital gown. Observation on 04/07/26 at 3:08 P.M. revealed Resident #102 was lying in bed wearing a hospital gown. Interview on 04/07/26 at 3:08 P.M. with Resident #102 confirmed she was lying in bed in a hospital gown and had asked CNA #577 several times to help her clean up and get dressed. Resident #102 confirmed the aide had not changed her incontinence brief since before breakfast. Interview on 04/07/26 at 3:08 P.M. with CNA #577 confirmed she had not assisted Resident #102 with personal care or since before breakfast. CNA #577 confirmed she is expected to change resident's incontinence briefs every two hours, but it had been over five hours since Resident #102 had been changed. Interview on 04/07/26 at 3:10 P.M. with LPN #414 confirmed she had directed CNA #577 to assist Resident #102 to get up and dressed after breakfast, but the aide had failed to do so. Review of the facility policy titled Supporting Activities of Daily Living revised March 2018 revealed residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and oral and personal hygiene. This deficiency represents noncompliance investigated under Complaint Numbers 2742114, 2705796, 2696092, 2681920, 2672061, 2669472 and 2649168.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview, review of the facility menu, and review of the facility policy, the facility failed to implement the menu as planned by the Registered Dietitian (RD). This affected 15 facility-identified residents who received a renal diet. The facility census was 119 residents. Findings include: Observation on 04/08/26 at 12:00 P.M. during lunch meal service revealed [NAME] #601 plated pasta salad for residents on a renal diet using a #16 size scoop and made grilled cheese sandwiches for residents on a renal diet using American cheese. Interview on 04/08/26 at 12:00 P.M. with [NAME] #601 and Diet Manger (DM) #600 verified the residents on a renal diet should have received Swiss cheese instead of American cheese. DM #600 verified the menu did not specify a portion size for the pasta salad for the residents on a renal diet. [NAME] #601 confirmed since the menu did not indicate a portion size for the pasta salad for the renal diet she decided to use the portion she thought would work. DM #600 verified the renal pasta portion should have been clarified by the RD. Review of the facility lunch menu dated 04/08/26 revealed the renal diet plan included pasta salad but did not indicate a portion size and a grilled cheese sandwich made two slices of bread and three slices of Swiss cheese. Review of facility policy titled Diet Order Interpretation undated revealed residents on a renal diet were allowed Swiss cheese and should avoid American cheese.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review, the facility failed to provide dignified care for Resident #58 who had an indwelling Foley catheter. This affected one (#58) of the four residents (#23, #58, #66 and #102) reviewed for dignity. The facility census was 119. Review of the medical record for Resident #58 revealed an admission date of 03/07/26 with diagnoses of congestive heart failure, acute cystitis with hematuria, chronic kidney disease state III and major depressive disorder. Review of the Minimum Data Set (MDS) admission assessment dated [DATE], revealed Resident #58 had moderate cognitive impairment and was always incontinent for bowel and had a catheter for the bladder. Observation of Resident #58's room on 04/06/26 at 11:00 A.M., revealed the resident's catheter bag was attached to the right-side bed frame facing the corridor and did not have a dignity bag. The urine in the bag was visible to all individuals in the corridor. During an interview on 04/06/26 at 11:03 A.M., Licensed Practical Nurse (LPN) #414 verified Resident #58's catheter bag did not have a dignity bag and should have had one. Review of policy titled, Quality of Life-Dignity, revised August 2009, revealed each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Demeaning practices and standards of care that compromise dignity are prohibited. Staff should promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered. This deficiency represents non-compliance investigated under Complaint Numbers 2806245.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interview and policy review, the facility failed to notify a resident's representative of medication changes. This affected one (#138) of the three residents reviewed for notification of change of status. The facility census was 119. Review of the closed medical records for Resident #138 revealed the resident was admitted to facility on 12/13/21. Diagnosis included cerebellar ataxia, dysphasia, vascular dementia, polyneuropathy, chronic pain syndrome, lower left extremity above the knee amputation and schizoaffective disorder. Resident was discharged to another skilled nursing facility on 11/11/25. Review of the closed medical record for Resident #138 dated 04/03/25, revealed an informed consent being done for genetic testing on 04/03/25 with a verbal consent being obtained from Resident #138 despite being severely cognitively impaired. No documentation that the resident's representative had given consent nor had been notified of genetic testing being done. Review of Minimum Data Set (MDS) assessment dated [DATE] for Resident #138 revealed resident severely cognitively impaired, was dependent for all activities of daily living (ADL) and was ordered antipsychotic medication, antianxiety medication and antidepressant medication. Review of physician orders for Resident #138 dated 07/17/25, revealed the resident was ordered Remeron. Review of closed medical record for Resident #138 for 07/17/25 revealed no documentation related to Resident #138's Representative being notified when mirtazapine was ordered for the resident on 07/17/25. During an interview on 04/07/26 at 5:51 P.M., Resident #138's Representative stated they discovered multiple medications the resident was taking when he was transferred to a new facility on 11/11/25. Resident #138's Representative stated she was unaware resident had been started on mirtazapine in July 2025 or why it was ordered. Resident #138's Representative stated she was not aware that genetic testing had been completed on the resident and was never notified or approved of the genetic testing or the results. During an interview on 04/08/26 at 3:10 P.M., Licensed Practical Nurse (LPN) #400 stated when a new order was written, the resident and their identified primary contact were to be notified, and the notification should be documented in the resident's record. LPN #400 confirmed there was no documentation indicating Resident #138's Representative had been notified of the mirtazapine order nor the genetic testing. LPN #400 stated the representative from the genetic testing company took care of getting the consent for any testing done and the facility staff were not involved in that process. Review of the policy titled, Change in a Resident's Condition or Status, revised February 2021, revealed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. This deficiency represents non-compliance investigated under Master Complaint Number 2970940 and Complaint Numbers 2681920, 2672061 and 2669472.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of Notice of Medicare Non-Coverage (NOMNC) documents, staff interview and facility policy, the facility failed to ensure the NOMNC was accurately completed. This affected three (Residents #143, #144 and #146) of five residents reviewed for Beneficiary Notification. The facility census was 119. 1) Review of the medical record revealed Resident #143 was admitted to the facility on [DATE] and discharged on 02/23/26. Diagnoses included asthma with acute exacerbation, diabetes mellitus type II and morbid obesity. Review of the census profile for Resident #143 revealed the resident was admitted to the facility on [DATE], transitioned to Medicare Part A on 02/01/26, and was discharged from the facility on 02/23/26. Review of the Minimum Data Set (MDS) Discharge-Return Not Anticipated assessment dated [DATE] revealed Resident #143 had intact cognition. Review of the Skilled Nursing Beneficiary Protection Notification Review completed by the facility revealed Resident #143 had a Medicare Part A skilled service episode start date of 02/01/26 and a last covered day of Medicare Part A service of 02/22/26. There was no documented evidence a NOMNC was provided to the resident. 2) Review of the medical record revealed Resident #144 was admitted to the facility on [DATE] and discharged [DATE]. Diagnoses included left femur fracture and diabetes mellitus type II. an Review of the MDS Discharge-Return Not Anticipated assessment dated [DATE] revealed Resident #144 had intact cognition. Review of the Skilled Nursing Beneficiary Protection Notification Review completed by the facility revealed Resident #144 had a Medicare Part A skilled service episode start date of 10/29/25 and a last covered day of Medicare Part A service of 12/02/25. There was no documented evidence a NOMNC was provided to the resident. 3) Review of the medical record revealed Resident #146 was admitted to the facility on [DATE] and discharge on 12/16/25. Diagnoses included acute embolism and thrombosis of right lower extremity and cerebral infarction with left (non-dominant) side hemiplegia/hemiparesis. Review of the census profile for Resident #146 revealed Resident #146 was admitted to the facility on [DATE], transitioned to Medicare Part A on 11/01/25, and discharged from the facility on 12/16/25. Review of the MDS Discharge-Return Not Anticipated assessment dated [DATE] revealed Resident #146 had intact cognition. Review of the Skilled Nursing Beneficiary Protection Notification Review completed by the facility revealed Resident #146 had a Medicare Part A skilled service episode start date of 09/25/25 (not correct) and a last covered day of Medicare Part A service of 12/15/25. There was no documented evidence a NOMNC was provided to the resident. During an interview on 04/08/2026 at 9:55 A.M., [NAME] President of Clinical Operations #950 verified the facility failed to provide Residents #143, #144, and #146 with a NOMNC upon discharge from Medicare Part A services. Review of the policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised September 2022, revealed residents are informed in advance when changes will occur to their bills. A Notice of Medicare Non-Coverage is issued to the resident at least two calendar days before benefits end. The Notice of Medicare Non-Coverage informs the resident of pending termination of coverage and of his/her right to an expedited review by a Quality Improvement Organization.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, review of facility's Self-Reported Incidents (SRI), and policy review, the facility failed to timely report an allegation of a missing item. This affected one (#02) resident of the one resident reviewed for reporting of potential abuse and misappropriation. The facility total census was 119. Record review of Resident #02 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #02 include respiratory failure, hypertension, diabetes, end stage renal disease, obesity, anxiety disorder, dependent on dialysis, cardiac defibrillator, and metabolic encephalopathy. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #02 had intact cognition and was dependent on staff assistance with Activities of Daily Living skill (ADL) and mobility. Review of the facility's Missing Item Report dated [DATE], revealed the Administrator received an allegation of a missing [NAME] pendent with diamonds from Resident #02. The resident stated a five-caret ruby with diamonds was given to her by her nephew. The Administrator called a family member on [DATE] who indicated there was no ruby given to the resident. There was no other documentation provided. During an interview on [DATE] at 9:15 A.M., Resident #02 stated her son was recently deceased and at the funeral, she was given a five-caret ruby pendent with diamonds. Resident #02 stated she was keeping the pendant in her bed so it wouldn't be stolen but it was gone. The resident stated she reported the missing pendant to the Administrator about two weeks ago. Review of the State of Ohio Certification and Licensure System (CALS) on [DATE] at 10:25 A.M, revealed no SRI was created for the allegation of misappropriation reported by Resident #02 on [DATE]. During an interview on [DATE] at 10:30 A.M., Administrator stated Resident #02 called her on [DATE] and alleged a pendent with ruby and diamonds from her deceased son was given to her at the funeral a few weeks ago and it was missing. The Administrator stated she went to the resident's room and searched for the ruby and could not find it. The Administrator stated she called one family member who stated the alleged family member that gave Resident #02 the ruby pendent with diamonds did not have a pendent to give to the resident. The Administrator verified she did not file an SRI and did not complete an investigation besides looking for the pendent in the resident's room and calling a family member. Review of facility policy titled, Abuse and Neglect Protocol, dated [DATE], revealed if an incident of suspected abuse occurs, the facility shall report immediately within 24 hours, if the event that caused suspicion does not result in bodily injury, to the state agency. Misappropriation is defined as deliberate misplacement or a resident's belongings. All reports of resident abuse shall be promptly and thoroughly investigated by facility management.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, review of facility's Self-Reported Incidents (SRI), and policy review, the facility failed to thoroughly investigate an allegation of misappropriation. This affected one (#02) resident of the one resident reviewed for reporting of potential abuse and misappropriation. The facility total census was 119. Record review of Resident #02 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #02 include respiratory failure, hypertension, diabetes, end stage renal disease, obesity, anxiety disorder, dependent on dialysis, cardiac defibrillator, and metabolic encephalopathy. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #02 had intact cognition and was dependent on staff assistance with Activities of Daily Living skill (ADL) and mobility. Review of the facility's Missing Item Report dated [DATE], revealed the Administrator received an allegation of a missing [NAME] pendent with diamonds from Resident #02. The resident stated a five-caret ruby with diamonds was given to her by her nephew. The Administrator called a family member on [DATE] who indicated there was no ruby given to the resident. There was no other documentation provided. During an interview on [DATE] at 9:15 A.M., Resident #02 stated her son was recently deceased and at the funeral, she was given a five-caret ruby pendent with diamonds. Resident #02 stated she was keeping the pendant in her bed so it wouldn't be stolen but it was gone. The resident stated she reported the missing pendant to the Administrator about two weeks ago. During an interview on [DATE] at 10:30 A.M., Administrator stated Resident #02 called her on [DATE] and alleged a pendent with ruby and diamonds from her deceased son was given to her at the funeral a few weeks ago and it was missing. The Administrator stated she went to the resident's room and searched for the ruby and could not find it. The Administrator stated she called one family member who stated the alleged family member that gave Resident #02 the ruby pendent with diamonds did not have a pendent to give to the resident. The Administrator verified she did not file an SRI and did not complete an investigation besides looking for the pendent in the resident's room and calling a family member. Review of facility policy titled, Abuse and Neglect Protocol, dated [DATE], revealed if an incident of suspected abuse occurs, the facility shall report immediately within 24 hours, if the event that caused suspicion does not result in bodily injury, to the state agency. Misappropriation is defined as deliberate misplacement or a resident's belongings. All reports of resident abuse shall be promptly and thoroughly investigated by facility management.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review, observation, staff interview, and resident interview, the facility failed to develop comprehensive care plans for residents regarding pain management and refusal of medications. This affected two (Residents #79 and #3) of three residents reviewed for care plans. The facility census was 119 residents. Findings include: 1. Review of the medical record for Resident #79 revealed an admission date of 02/14/26 with diagnoses including acute pyelonephritis, calculus in bladder and kidney, chronic kidney disease, and diabetes mellitus type. Review of the MDS assessment for Resident #79 dated 02/19/26 revealed the resident had intact cognition and required staff assistance with ADLs. Review of the physician's orders for Resident #79 revealed orders dated 02/15/26 for Lyrica give one tablet by mouth two times a day for chronic pain syndrome, hold for sedation and Robaxin give one tablet by mouth four times a day for pain. Review of the care plan for Resident #79 dated 02/16/26 revealed it did not include a care plan regarding pain management. Review of the pain assessment for Resident #79 dated 04/07/26 revealed the resident had severe pain frequently over the previous five days that had interfered with her ability to sleep. Observation on 04/06/26 at 10:19 A.M. revealed Resident #79 was in bed and constantly moving with a pained expression on her face. Interview on 04/06/26 at 10:19 A.M. with Resident #79 confirmed the resident complained of urinary frequency and flank pain due to a kidney stone. The resident stated her pain was 10 out of 10 on a scale of 1 to 10 with 10 being the worst pain. Interview on 04/09/26 at 3:38 P.M. with the Director of Nursing (DON) verified Resident #79's care plan did not address the resident's need for pain management. 2. Review of the medical record for Resident #3 revealed an admission date of 03/20/24 with diagnoses including end stage renal disease and diabetes mellitus type one. Review of the care plan for Resident #3 dated 03/21/24 revealed the care plan did not have a focus regarding the resident's frequent refusal of medications. Review of the physician's orders for Resident #3 dated April 2026 revealed orders for Lyrica, Renvela, calcium carbonate, trazodone, and Prostat. Review of the progress note for Resident #3 dated 04/02/26 at 11:23 P.M. revealed the resident refused Renvela. Review of the progress note for Resident #3 dated 04/03/26 at 7:15 A.M. revealed the resident refused calcium carbonate and Renvela. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note for Resident #3 dated 04/05/26 at 12:34 A.M. revealed the resident refused trazodone. Review of the progress note for Resident #3 dated 04/05/26 at 2:00 A.M. revealed the resident refused calcium carbonate and Prostat. Review of the progress note for Resident #3 dated 04/05/26 at 6:41 A.M. revealed the resident refused calcium carbonate and Renvela. Review of the progress note for Resident #3 and 04/05/26 at 1:03 P.M. revealed the resident refused calcium carbonate and Renvela. Interview on 04/06/26 at 12:45 P.M. with Licensed Practical Nurse (LPN) #404 confirmed Resident #3 had a history of frequently refused medications throughout his stay at the facility. Interview on 04/06/26 at 2:00 P.M. with Unit Manager (UM) #400 verified Resident #3's care plan did not reflect the resident's frequent refusal of medications. This deficiency represents non-compliance investigated under Complaint Number 2649168.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure timely care and treatment for a resident exhibiting a change in condition. This affected one (Resident #141) of 26 residents sampled. Based on medical record review, staff interview, and review of the facility policy, the facility also failed to arrange follow-up medical tests. This affected one (Resident #138) of 26 residents sampled. The facility census was 119 residents. Findings include: 1. Review of the medical record for Resident #141 revealed an admission date of 01/13/25 with diagnoses including hypertensive heart disease, cerebral infarction, hemiplegia and hemiparesis affecting right side, diabetes mellitus and a discharge date of 02/11/26. Review of the care plan for Resident #141 dated 01/29/26 revealed the resident had an activities of daily living (ADL) self-care deficit and was a substantial one person assist with bed mobility, dressing, and grooming. Review of the Medication Administration Records (MARs) for Resident #141 dated January 2026, and February 2026 revealed the resident was administered Tramadol for pain on the following date with the corresponding pain levels on a scale of one to 10 with 10 being the worst pain: 01/31/26-pain level of 7, 02/01/26-pain level of 8, 02/07/26-pain level of 7, 02/09/26-pain level of 9, 02/10/26-pain level of 10, 02/11/26-pain level of 9. Review of the Minimum Data Set (MDS) assessment for Resident #141 dated 02/11/26 revealed the resident had moderately impaired cognition and was dependent on staff for activities of daily living (ADLs). Review of the progress note for Resident #141 dated 01/31/26 at 8:58 A.M. per Licensed Practical Nurse (LPN) #370 revealed the resident refused to get up from bed and showed signs of pain. Review of the progress note for Resident #141 dated 02/05/26 at 7:26 A.M. per LPN #370 revealed the resident refused to get up despite three staff attempts and showed non-verbal signs of pain. Review of the progress note for Resident #141 dated 02/09/26 at 8:26 A.M. per LPN #370 revealed the resident refused to get out of the bed and displayed signs of pain. Review of the progress note for Resident #141 dated 02/09/26 at 8:58 A.M. revealed displayed signs of pain and the staff administered Tramadol which was ineffective. Review of the progress note for Resident #141 dated 02/10/26 per NP #997 revealed the provider assessed the resident for pain to the left knee and left shoulder. Resident #141 refused lab work, and the plan was to continue gabapentin and Tramadol for pain. Review of the order summary for Resident #141 revealed an order dated 02/10/26 for an immediate (STAT) x-ray to the left shoulder and the left hip and an order dated 02/11/26 to send the resident to the emergency room (ER) for evaluation. Review of the x-ray results for Resident #141 dated 02/10/26 at 9:40 P.M. revealed the resident had a fracture of the left femur. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Clovernook Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7025 Clovernook Avenue Cincinnati, OH 45231	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note for Resident #141 dated 02/11/26 at 9:06 A.M. per LPN #370 revealed the nurse reported x-ray results to the Nurse Practitioner (NP) #999 who gave an order to send the resident to the hospital. Review of the progress note for Resident #141 dated 02/11/26 at 10:21 A.M. per Registered Nurse (RN) #350 revealed the nurse completed a head-to-toe assessment of the resident related to increased pain to the left shoulder, left hip, and left thigh. Per report staff gave Resident #141 pain medication at 6:00 A.M. Review of the progress note for Resident #141 dated 02/11/26 at 2:27 P.M. revealed the resident was transferred to the emergency room via 911 transport per NP#999's order. Review of the hospital note for Resident #14 dated 02/11/26 at 7:11 P.M. revealed the resident presented to the emergency department with a left hip fracture. Resident #141 was admitted to the hospital and had orthopedic surgery to repair the fracture on 02/12/26. Interview on 04/09/26 at 3:00 P.M. with the Medical Director (MD) confirmed the facility notified his office of Resident #102's leg pain on 02/10/26 at 12:27 P.M. and an order for a stat x-ray was provided on 02/10/26 at 12:27 P.M. The x-ray results were reported on 02/10/26 at 9:40 P.M. in the facility's electronic record. The results for the x-ray were provided to NP #99 and an order for Resident #141 to be sent out for evaluation and treatment was given on 02/11/26 at 9:15 A.M. The MD stated the 12 hours between the time the x-ray was noted as reported to the facility and the physician's group being notified of the results was unusually long and an indication of a breakdown in the system of reporting. Interview on 04/09/26 at 3:05 P.M. with Licensed Practical Nurse confirmed she received Resident #141's x-ray results which indicated the resident had a fracture of the left femur on 02/10/26 at approximately 9:45 P.M. LPN #370 stated she called the physician on call and left a message but did not document the call to the on-call physician. LPN #370 confirmed Resident #141 had significant pain during the night and did not want to get out of bed. LPN #370 stated her shift ended at 7:00 A.M. on 02/11/26 and she reported on Resident #141's status to Registered Nurse (RN) #350 at shift change. Interview on 04/09/26 at 3:48 P.M. with the radiology company who completed the x-ray for Resident #141 on 02/10/26 confirmed the results were faxed to the facility on [DATE] at 9:41 P.M., 10:02 P.M., and 10:05 P.M., and the radiology company called the facility and left a voice mail regarding the x-ray results for the resident on 02/10/26 at 10:02 P.M. Interview on 04/09/26 at 3:11 P.M. with RN #350 on 04/09/26 at 3:11 P.M. confirmed she was the day shift nurse for Resident #141 on 02/11/26 and the resident showed signs of severe pain. RN #350 confirmed she asked NP #999 if the resident could be sent to the hospital via 911, but the NP said non-emergent transport was okay. Interview on 04/09/26 at 3:19 P.M. with LPN #400 confirmed NP#999 had stated it was okay to send Resident #141 to the hospital on [DATE] via non-emergency transport. Regional Nurse (RN) #998 recommended Resident #141 be sent to the hospital via 911 and the resident left via 911 on 02/11/26 at 1:50 P.M. Interview on 04/09/26 at 4:11 P.M. with the Director of Nursing (DON) confirmed the facility staff failed to call and notify her of Resident #141's fracture on the evening of 02/10/26. The DON stated it (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not unusual for the on-call provider to call back the next day if a nurse left a voicemail after hours. Interview on 04/10/26 at 7:15 A.M. with NP #999 confirmed she assessed Resident #141 on the morning of 02/11/26 at approximately 8:30 A.M. for a confirmed fracture and gave an order to send the resident to the hospital via non-emergent transport. NP #999 stated she was never told the transportation could take hours for Resident #141 to be transported, and the facility did the right thing to send Resident #141 out via 911 transport. NP#999 confirmed she did not know why there was no response from the call the facility placed to the physician on call on 02/10/26. Review of the facility policy titled Change in a Residents Condition or Status dated 01/22/22 revealed the facility would promptly notify the resident, attending physician, and resident representative of changes in the resident's medical condition or status. The nurse will notify the resident's physician on call when there has been discovery of an injury of unknown source, a need to transfer a resident to a hospital, and to notify of a change in condition. 2. Review of the medical record for Resident #138 revealed an admission date of 12/13/21 with diagnoses including cerebellar ataxia, dysphagia, and vascular dementia. Review of the MDS assessment for Resident #138 dated 07/11/25 revealed the resident was severely cognitively impaired and was dependent on staff for ADLs. Review of the results of a modified barium swallow (MBS) for Resident #138 dated 07/28/25 revealed the hospital was not able to obtain meaningful results due to the resident's inability to follow instructions. The follow up recommendation was for the facility to obtain a physician's order for a more extensive test, a modified barium swallow study (MBSS.) Review of the medical record for Resident #138 revealed there were no orders for an MBSS. Interview on 04/07/26 at 3:20 P.M. with the DON confirmed she was not aware the hospital paperwork from Resident #138's MBS on 07/28/25 had recommended obtaining an order for an MBSS. The DON stated the facility unit managers were to review documents and orders when residents returned from appointments to make sure all follow up was done. The DON confirmed the facility had not obtained an order for an MBSS for Resident #138 following the MBS on 07/28/25. Interview on 04/07/26 at 3:24 P.M. with LPN Unit Manager (LPN/UM)#400 confirmed she was not sure who had reviewed Resident #138's paperwork following the appointment on 07/28/25, but the nurse confirmed no one from the facility had obtained an order and scheduled an MBSS for the resident as was recommended on the paperwork. Interview on 04/07/26 at 5:51 P.M with Resident #138's representative confirmed she accompanied Resident #138 to the MBS on 07/28/25 and she returned with paperwork from the hospital indicating the follow up was for the facility to obtain a physician's order for an MBSS. Resident #138's representative stated she had not heard back from the facility regarding a follow-up MBSS. Interview on 04/07/26 at 3:24 P.M. with LPN Unit Manager (LPN/UM)#400 confirmed she was not sure who had reviewed Resident #138's paperwork following the appointment on 07/28/25, but the nurse confirmed no one from the facility had obtained an order and scheduled an MBSS for the resident as was recommended on the paperwork. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Number 2696092.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, resident interview, and review of the facility policy, the facility failed to ensure staff assessed residents for smoking safety and implemented safe smoking interventions. This affected one (Resident #126) of four residents reviewed for accidents and hazards. Based on medical record review, observation, staff interview, resident interview, and review of the facility policy the facility also failed to ensure staff maneuvered resident shower chairs in a safe manner to prevent falls. This affected one (Resident #67) of four residents reviewed for accidents and hazards. The facility census was 119 residents. Findings include: 1. Review of the medical record for Resident #126 revealed an admission date of 03/20/26 with diagnoses including malignant neoplasm of the lip with status post skin graft. Review of the Minimum Data Set (MDS) assessment for Resident #126 dated 03/26/26 revealed the resident had impaired cognition and required supervision with activities of daily living (ADLs.) Review of the smoking safety evaluation for Resident #126 dated 03/20/26 revealed the resident was not a smoker. There were no additional smoking assessments after the assessment performed on 03/20/26. Review of care plan for Resident #126 updated 03/27/26 revealed the resident was a smoker and was encouraged not to smoke due to oral cancer and tracheostomy. Interventions included the following: instruct the resident about smoking cessation and policies of smoking, observe the resident's clothing and skin for sign of cigarette burns. Review of a nurse progress note for Resident #126 dated 03/29/26 at 11:49 A.M. revealed while the nurse was administering a bolus tube feeding to resident, the tube was leaking from what appeared to be from a cigarette burn on the tube. Review of a nurse progress note for Resident #126 dated 04/04/26 at 10:00 P.M. revealed staff found resident sitting in his wheelchair on his patio smoking a cigarette. The staff took the cigarette and counseled the resident that smoking was prohibited in the facility and searched his room to locate any additional cigarettes. Observation on 04/06/26 at 9:30 A.M. revealed Resident #126 got a pack of cigarettes from his nightstand and exited the room. Interview on 04/06/26 at 9:30 A.M. with Resident #126 confirmed he was going to smoke. Interview on 04/08/26 at 12:05 P.M. with Certified Nursing Assistant (CNA) #530 stated she found Resident #126 on 04/04/26 smoking on his patio. Interview on 04/09/26 at 12:43 P.M. with the Administrator verified the facility had not completed a smoking assessment for Resident #126 following the initial assessment completed on 03/20/26 which indicated the resident was not a smoker. The Administrator confirmed the facility had not implemented specific interventions to ensure the resident's safety following the discovery of the cigarette burn on the resident's feeding tube on 03/29/26 nor following the discovery of the resident smoking on his patio on 04/04/26. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Smoking Policy dated October 2023 revealed resident smoking status was evaluated upon admission and change in condition to determine if the resident was a smoker. If the resident is a smoker the facility should complete an evaluation including determining the resident's ability to smoke safely with or without supervision. All smoking restrictions and interventions are then noted on the care plan. Residents were not permitted to keep cigarettes lighters and smoking items in their possession. 2. Review of the medical record for Resident #67 revealed an admission date of 12/01/25 with diagnoses including constipation, insomnia, and spinal stenosis. Review of the MDS assessment for Resident #67 dated 03/05/26 revealed the resident was cognitively intact and required maximum assistance of staff with bathing. Review of a progress note for Resident #67 dated 02/18/26 at 11:30 P.M. per Registered Nurse (RN) #858 revealed Certified Nursing Assistant (CNA) #511 told her the resident had fallen in the shower room during transfer. Review of the fall investigation for Resident #67 dated 02/18/26 at 3:30 P.M. revealed CNAs #511 and #1001 notified RN#858 the resident had fallen forward out of the shower chair when it was maneuvered over a short elevation in the flooring. Resident #67 did not sustain injuries related to the fall. The contributing environmental factor was listed as uneven flooring in the shower room and instability while crossing an elevation. The root cause was failure to maintain resident stability and positioning during transport in the shower chair, particularly while maneuvering over a floor elevation. The intervention was to educate staff to use a reclining shower chair for Resident #67's showers. Interview on 04/06/26 at 9:50 A.M. with Resident #67 confirmed he had fallen out of his shower chair on 02/18/26 when CNA #1001 pushed him forward over a hump on the floor of the shower room causing him to fall forward out of the chair. Resident #67 stated he told CNA #1001 to pull him backwards in the shower chair in order to get the chair over the hump in the floor of the shower room. Resident #67 verified CNA #1001 continued pushing him forward despite his protests and then he fell out of the shower chair. Observation on 04/06/26 at 10:51 A.M. of the three hundred hallway shower room floor revealed there was a large hump in the shower room floor. Interview on 04/06/26 at 10:51 A.M with CNA #590 confirmed the three hundred hallway shower room floor had a large hump in the middle of the floor. CNA #590 stated the shower chairs have wheels on them, and it was necessary for safety to pull the resident shower chair backwards up the hill and to not push the chair up the hump/elevation in order to keep residents from falling forward. Interview on 04/08/26 at 12:45 P.M. with Licensed Practical Nurse (LPN) #400 confirmed the three hundred hallway shower room floor had a large hump in the middle of the floor. LPN #400 confirmed it was safer for staff to pull residents backward up the hump/elevation in the floor versus pushing the resident forward up hump which could cause the resident to fall forward out of the chair. Interview on 04/08/26 at 4:45 P.M. with Maintenance Supervisor (MS) #200 confirmed there was a hump in the center of the three hundred hallway shower room floor. Interview on 04/09/26 at 11:42 A.M with CNA#511 confirmed she was with Resident #67 when he fell (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on [DATE]. CNA #511 stated when she entered the shower room CNA #1001 was already in the shower room with Resident #67 and was pushing the resident forward up the hump in the shower room floor causing the resident to fall forward out of the chair. CNA #511 confirmed for safety staff should pull the residents backwards over the hump on the floor to keep the residents from falling forward out of the chair. Review of the facility policy titled Assessing Falls and Their Causes dated October 2010 the facility will identify and use appropriate interventions to prevent falls. This deficiency represents noncompliance investigated under Complaint Number 2742114 and Complaint Number 2708763.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on medical record review, observation, staff interview, resident interview, and review of the facility policy, the facility failed to ensure staff followed residents' fluid restrictions. This affected three (Residents #6, #111 and #29) of three residents reviewed for fluid restrictions. The facility census was 119 residents. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of 06/20/23 with diagnoses including pulmonary hypertension, bradycardia, and heart failure. Review of the Minimum Data Set, (MDS) assessment for Resident #6 dated 02/19/26 revealed the resident had impaired cognition and required maximum assistance of staff for activities of daily living (ADLs.) Review of the nutritional assessment for Resident #6 dated 03/31/26 per the Registered Dietitian (RD) revealed the resident was to be on a 1500 milliliter (ml) fluid restriction with dietary to provide 840 ml and nursing to provide 660 ml. Review of Medication Administration Record (MAR) for Resident #6 revealed on 04/04/26 the resident #6 received 1680 ml of fluid in a 24-hour period. Review of the care plan for Resident #6 revealed the plan was updated on 04/07/26 to include the resident's fluid restriction. Review of the Certified Nursing Assistant (CNA) care plan for Resident #6 revealed it did include monitoring of fluid restriction as a task. Observation on 04/08/26 at 12:05 P.M. of the lunch meal revealed Resident #6 received no fluids. Resident #6's meal ticket did not contain information regarding the resident's fluid restriction. Interview on 04/08/26 at 12:05 P.M. with CNA #530 verified Resident #6 was to receive some fluids for each meal. CNA #530 stated she did not know Resident #6 was on a fluid restriction and the fluid restriction order was not listed on the CNA care plan. CNA #530 further verified the dietary fluid was not listed on Resident #6's meal ticket to monitor the fluid provided at each meal. Interview on 04/08/26 at 1:05 P.M. with Diet Manager (DM) #600 verified there was no fluid restriction noted on Resident #6's meal tickets and verified according to the facility's fluid restriction instruction sheet, the resident was to receive 240 ml of fluid at lunch meals. Review of the fluid restriction instruction sheet revealed residents on a 1500 ml per day fluid restriction should receive 250 ml of fluid at lunch from the dietary department. 2. Review of the medical record for Resident #111 revealed an admission date of 05/30/23 with diagnoses including congestive heart disease, chronic kidney disease and diabetes. Review of the MDS assessment for Resident #111 dated 03/14/26 revealed the resident had intact cognition and was independent with ADLs. Review of the physician's orders for Resident #111 dated April 2026 revealed orders for a renal diet and a 2000ml fluid restriction with 740 ml for nursing and 1260 for dietary per day. Review of the care plan for Resident #111 revealed there was no care plan for fluid restriction. Review of the CNA care plan for Resident #111 revealed it did not include monitoring of fluid restriction as a task. Review of meal tickets for Resident #111 for breakfast, lunch and supper dated 04/08/26 revealed there was no documentation of a fluid restriction for the dietary department. Interview on 04/08/26 at 12:05 P.M. with CNA #530 confirmed she did not know Resident #111 was on a fluid restriction and the fluid restriction order was not listed on the CNA care plan. Observation on 04/08/26 at 12:30 P.M. of Resident #111 revealed the resident had a water pitcher of 960 ml of water provided by the facility on her overbed table and 480 ml fluid on her meal tray. Interview on 04/08/26 at 12:30 P.M. with Resident #111 confirmed the dietary and nursing departments do not follow her fluid restriction, and they gave her two to three cups of fluid at each meal and the full water pitcher each day. Interview on 04/08/26 at 1:05 P.M. with DM #600 verified there was no fluid restriction noted on Resident #111's meal ticket. Review of the fluid restriction instruction sheet revealed for a 2000 ml per day fluid restriction the resident should receive 420 ml of fluid at lunch from the dietary department. 3. Review of the medical record for Resident #29 revealed an admission date of 12/15/23 with diagnoses including end stage renal disease, and dependence on dialysis. Review of the MDS assessment for Resident #29 dated 02/17/26 revealed the resident had slightly impaired cognition and required supervision set up for ADLs. Review of the physician's orders for Resident #29 dated April 2026 revealed orders for a renal diet and a 1500ml fluid restriction with 840 ml for nursing and 660 ml for (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dietary per day. Review of the care plan for Resident #29 revealed there was no care plan for fluid restriction. Review of the CNA care plan for Resident #29 revealed it did not include monitoring of fluid restriction as a task. Review of the meal tickets for Resident #29 for breakfast, lunch and supper dated 04/08/26 revealed there was no documentation of a fluid restriction for the dietary department. Review of the dialysis record for Resident #29 dated 04/06/26 revealed the resident was 0.5 kilograms over his dry weight with 1500 ml of fluid removed. Review of the dialysis record for Resident #29 dated 04/08/26 the resident had 3000 ml of fluid removed. Observation 04/08/26 at 12:35 P.M. revealed Resident #29 had a water container of approximately 720 ml of water provided by the facility on his overbed table and 240ml fluid on his meal tray. Interview on 04/08/26 at 12:35 P.M. with Resident #29 confirmed the dietary and the nursing do not follow his fluid restriction. Resident #29 stated the CNAs fill up his 20-ounce personal water cup one to two times a day. Resident #29 stated he was recently verbally counseled by the dialysis nurse after dialysis this week because he was over his dry weight due to having too much fluid intake. Interview on 04/09/26 at 11:15 A.M with Unit Manager (UM) # 400 verified when a resident is on a fluid restriction staff should remove water pitchers from the resident's room. The fluid restriction should be listed in the CNA plan so the aides can assist in implementing the fluid restriction. Interview on 04/09/26 at 12:43 P.M with the Administrator confirmed residents with a fluid restriction should be documented on the meal tickets and the CNA care plan, and the fluid restriction must be followed by dietary and nursing departments. Review of the facility policy titled Encouraging and Restricting Fluids dated 2010 revealed when a resident was on fluid restriction staff should remove the water pitcher and cup from the resident's room, review the resident's care plan to assess for any special needs, and follow the specific instructions concerning fluid restrictions. This deficiency represents noncompliance investigated under Complaint Number 2681920 and Complaint Number 2672061.		

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on medical record review, staff interview, resident interview, and review of the facility policy, the facility failed to routinely assess and document resident pain and monitor the effectiveness of pain medications. This affected one (Resident #79) of three residents reviewed for pain management. The facility identified 33 residents on a pain management program. The facility census was 119 residents. Findings include: Review of the medical record for Resident #79 revealed an admission date of 02/14/26 with diagnoses including acute pyelonephritis, calculus in bladder and kidney, chronic kidney disease, and diabetes mellitus type two. Review of the physician's orders for Resident #79 revealed orders dated 02/15/26 for Lyrica 50 milligrams (mg) give one tablet by mouth two times a day for chronic pain syndrome and hold for sedation and Robaxin 500 mg give one tablet by mouth four times a day for pain. Review of the Minimum Data Set (MDS) assessment for Resident #79 dated 02/19/26 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.) Review of the Medication Administration Records (MARs) for Resident #79 dated February 2026, March 2026 and April 2026 revealed there was no documentation of the resident's pain level prior to administration of Lyrica and of Robaxin and no documentation of the effectiveness of the medications in relieving the resident's pain. Interview on 04/07/26 at 2:33 P.M. with Resident #79 confirmed her stated her current pain level was six to seven on a scale of one to 10 with 10 being the worst pain. Resident #79 stated since she had been at the facility no one had asked her about her pain level. Interview on 04/07/25 at 3:01 P.M. with the Director of Nursing (DON) confirmed she was unaware Resident #79 had a kidney stone and had complained of unrelieved pain. The DON confirmed the nurses had not documented Resident 79's pain level before and after administration of pain medication in the resident's MARs dated February 2026, March 2026, and April 2026. The DON verified the expectation was for staff to document the level of pain each time a pain medication was administered. Interview on 04/08/2026 at 8:51 A.M. with Certified Nurse Practitioner (CNP) #925 verified staff had not communicated Resident #79's pain levels and/or that the current pain regimen was not effective in controlling Resident #79's pain. Review of the policy titled Pain Assessment and Management revised March 2015 revealed staff should assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and should assess pain at least weekly for stable chronic pain. Staff should document the resident's reported level of pain with adequate detail, i.e. enough information to gauge the status of pain and the effectiveness of interventions for pain.		