

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  Seven Acres Senior Living at Clifton		STREET ADDRESS, CITY, STATE, ZIP CODE  476 Riddle Road Cincinnati, OH 45220	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39967</p> <p>Based on interview and record review, the facility failed to ensure a resident's pain was addressed. This affected one resident (#29) of one resident reviewed for pain. The facility census was 52.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #29 admitted to the facility on [DATE] with diagnoses including hypertensive heart disease with heart failure, pulmonary hypertension, congestive heart failure, type two diabetes mellitus with diabetic neuropathy, hyperlipidemia, bipolar disorder, gastro esophageal reflux disease without esophagitis, post traumatic stress disorder, anemia, asthma, restless legs syndrome, obstructive sleep apnea, and major depressive disorder.</p> <p>Review of Resident #29's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #29 received opioid medication during the review period and rated her worst pain over the past five days as a four out of ten.</p> <p>Review of Resident #29's opioid medication care plan dated 04/08/24 revealed Resident #29 used opioid medication for treatment of chronic pain. Interventions included administer opioid medication as ordered by the physician and monitor for side effects and effectiveness, the physician to review medications for possible dose reduction and monitor, document, and report as needed any adverse reactions of medications.</p> <p>Review of Resident #29's pain care plan dated 03/19/24 revealed Resident #29 had chronic pain due to neuropathy, an old injury of the back from a fall, radiculopathy lumbosacral region, restless leg syndrome, arthropathy, diabetes mellitus neuropathy, and chronic headaches. Interventions included administer analgesia and medication for treatment of pain per orders, evaluate the effectiveness of pain interventions, monitor and document for side effects of pain medication, monitor and record pain characteristics and monitor and report to nurse any signs and symptoms of nonverbal pain.</p> <p>Review of Resident #29's physician order dated 05/26/23 and discontinued 04/22/24 revealed Resident #29 was ordered Oxycodone 10 milligrams (mg) give two tablets by mouth two times a day for pain and give two tablets by mouth every eight hours as needed for pain.</p> <p>Review of Resident #29's physician order dated 04/08/24 revealed Resident #29 was ordered Oxycodone 10 mg give two tablets by mouth two times a day for pain and give two tablets by mouth every eight hours as needed for pain.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #29's physician order dated 03/09/23 revealed Resident #29 was ordered Lyrica 200 mg give by mouth three times a day for pain.</p> <p>Review of Resident #29's Medication Administration Record (MAR) from 04/01/24 to 4/30/24 revealed Resident #29's Oxycodone was not given on 04/05/24 at 6:00 A.M., 04/05/24 at 7:00 P.M., 04/06/24 at 6:00 A.M., 04/06/24 at 7:00 P.M., 04/07/24 at 6:00 A.M., 04/07/24 at 7:00 P.M., 04/08/24 at 6:00 A.M., 04/16/24 at 7:00 P.M., 04/18/24 at 7:00 P.M. and on 04/23/24 at 6:00 A.M. Resident #29's MAR listed her pain level as a seven on 04/06/24 at 7:00 P.M. and an ten on 04/08/24 at 6:00 A.M. when her pain medication was not given. Resident #29 did not receive any as needed Oxycodone on 04/05/24, 04/06/24, 04/07/24, 04/08/24, 04/16/24, 04/18/24 and on 04/23/24. Resident #29's Lyrica 200 mg was not given on 04/16/24 at 8:00 P.M., 04/18/24 at 8:00 P.M., 04/20/24 at 12:00 P.M., 04/21/24 at 8:00 A.M., 04/21/24 at 12:00 P.M., 04/21/24 at 8:00 P.M., 04/22/24 at 8:00 A.M., and on 04/22/24 at 12:00 P.M. Further review of the MAR revealed Resident #29's pain assessment was a zero on day shift, a four on evening shift and a five on night shift on 04/05/24, a zero for all three shifts on 04/06/24, a zero on day and evening shift and a ten on night shift on 04/07/24, a ten on day shift, a nine on evening shift and a zero on night shift on 04/08/24, a zero on day and evening shift on 04/16/24, a zero on day and evening shift on 04/18/24 and a seven on day shift and a zero on night shift on 04/23/24.</p> <p>Review of the facility's fax dated 04/03/23 revealed a request to refill Resident #29's Oxycodone was sent to Resident #29's physician.</p> <p>Review of Resident #29's progress note dated 04/06/24 revealed the facility was awaiting Resident #29's Oxycodone 10 mg from the pharmacy.</p> <p>Review of the facility's fax dated 04/07/24 revealed Resident #29 continued with pain complaints. Resident #29 needed Oxycodone refilled. Physician #950 sent back a response that stated, print script and I'll fill out. The facility sent another response to Physician #950 that stated the facility was unable to print a script at that time and asked if Physician #950 could call it in. Physician #950 sent another response that stated no and we don't do refills on the weekends, and I was in Friday.</p> <p>Review of Resident #29's progress note dated 04/07/24 revealed the pharmacy was unable to send Resident #29's Oxycodone and the physician was unable to call into the pharmacy and unable to send a prescription. A hard copy prescription was requested, and staff will fax in the morning.</p> <p>Review of Resident #29's progress note dated 04/07/24 revealed Resident #29's Oxycodone was on order and will be given upon arrival.</p> <p>Review of Resident #29's progress note dated 04/20/24 revealed the pharmacy was notified to send Resident #29's Lyrica.</p> <p>Review of Resident #29's progress note dated 04/21/24 revealed Resident #29's Lyrica was not available.</p> <p>Review of Resident #29's progress note dated 04/20/24 revealed the facility was awaiting Resident #29's Lyrica from the pharmacy.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident #29 on 05/02/24 at 9:45 A.M. revealed Resident #29 was laying in her bed in her room. Resident #29 was clean and appropriately dressed.</p> <p>Interview with Resident #29 on 05/02/24 at 9:45 A.M. revealed Resident #29 did not receive her Oxycodone one weekend and her Lyrica on a different weekend due to her medications running out and the pharmacy being unable to refill her medication on the weekend. Resident #29 did not remember the dates she did not receive her Oxycodone or her Lyrica but reported she was in pain both weekends. Resident #29 reported she was given Tylenol for pain on both weekends but that did not help with her pain.</p> <p>Interview with the Director of Nursing (DON) on 05/02/24 at 3:15 P.M. verified Resident #29's Oxycodone 10 mg give two tablets by mouth two times a day for pain was not given on 04/05/24 at 6:00 A.M., 04/05/24 at 7:00 P.M., 04/06/24 at 6:00 A.M., 04/06/24 at 7:00 P.M., 04/07/24 at 6:00 A.M., 04/07/24 at 7:00 P.M., 04/08/24 at 6:00 A.M., 04/16/24 at 7:00 P.M., 04/18/24 at 7:00 P.M. and on 04/23/24 at 6:00 A.M. The DON also confirmed Resident #29's MAR listed her pain level as a seven on 04/06/24 at 7:00 P.M. and a ten on 04/08/24 at 6:00 A.M. when her pain medication was not given. The DON also verified Resident #29 did not receive any as needed Oxycodone on 04/05/24, 04/06/24, 04/07/24, 04/08/24, 04/16/24, 04/18/24 and on 04/23/24 due to the facility not having any Oxycodone in the emergency box and Resident #29 not having any Oxycodone in the facility because the as needed and routine Oxycodone was on the same medication card. The DON also confirmed Resident #29's Lyrica 200 mg give by mouth three times a day for pain was not given on 04/16/24 at 8:00 P.M., 04/18/24 at 8:00 P.M., 04/20/24 at 12:00 P.M., 04/21/24 at 8:00 A.M., 04/21/24 at 12:00 P.M., 04/21/24 at 8:00 P.M., 04/22/24 at 8:00 A.M., and on 04/22/24 at 12:00 P.M. The DON also confirmed Resident #29's pain assessment on the MAR on 04/05/24 was a zero on day shift, a four on evening shift and a five on night shift on 04/05/24, a zero for all three shifts on 04/06/24, a zero on day and evening shift and a ten on night shift on 04/07/24, a ten on day shift, a nine on evening shift and a zero on night shift on 04/08/24, a zero on day and evening shift on 04/16/24, a zero on day and evening shift on 04/18/24 and a seven on day shift and a zero on night shift on 04/23/24. The DON stated the facility had sent a refill request for Resident #29's Oxycodone to Physician #950 on 04/03/24 prior to Resident #29 running out of Oxycodone. The DON reported Resident #29's last Oxycodone was administered on 04/04/24 and Tylenol was administered on 04/05/25 and 04/06/24. The DON stated the facility sent faxes to Physician #950 on 04/07/24 and Physician #950 sent back a note stating that they would not refill Resident #29's Oxycodone on the weekends. The DON reported Resident #29's Lyrica refill request was sent to the pharmacy, but the pharmacy had an error and did not send the medication.</p> <p>Review of the pain assessment and management policy dated September 2021 revealed pharmacological interventions may be prescribed to manage pain.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152828 and OH00152846.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39702</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's insulin pen was primed according to manufacturer guidelines resulting in a significant medication error. This affected one (Resident #8) of five residents observed for medication administration. The facility census was 52.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #8 revealed an admitted [DATE]. Medical diagnoses included but were not limited to diabetes mellitus, [NAME] syndrome, dementia and heart failure.</p> <p>Review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. Resident #8 required moderate assistance for toileting, transfers, and bed mobility.</p> <p>Review of the active physicians orders for Resident #8 revealed an order dated 03/20/24 for NovoLOG Injection Solution 100 unit/milliliters (ml) (Insulin Aspart), inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, over 400 call the physician, subcutaneously before meals and at bedtime for diabetes mellitus.</p> <p>Observation on 05/08/24 at 11:50 A.M. of Registered Nurse #00 administering medications to Resident #8 revealed during the administration of 2 units of novolog injection solution, RN #00 took the cap off of the Novolog pen, swabbed the hub with alcohol, applied the needle but did not prime it before she turned the dial to 2. RN #00 verified she failed to prime the needle prior to drawing up the prescribed 2 units of insulin.</p> <p>Review of the manufacturer's instruction for Novolog insulin revealed step seven was to prime the pen by turning the dose selector to two units and while holding the pen up push and hold the green push button and ensure a drop of insulin appeared at the needle tip.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152846.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39702</p> <p>Based on medical record review, observation, and interviews, the facility failed to ensure nurses handled resident medications in a sanitary manner. This affected two (Residents #3 #22) of five residents observed for medication administration. Facility census was 52.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including but not limited to dementia without behavioral disturbances, hypertension, wernicke's encephalopathy, anemia, and alcoholic cirrhosis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 revealed intact cognition. Resident #3 was dependent for toileting and transfers, and required moderate assistance for bed mobility and transfers.</p> <p>Review of the active physicians orders for Resident #3 revealed an order for cranberry oral tablet give two tablets by mouth three times a day.</p> <p>Observation on 05/08/24 at 11:20 A.M. of medication administration with Registered Nurse (RN) #225 to Resident #3 revealed the nurse carried the large bottle of facility stock (medications used for multiple residents) cranberry tablets into the resident's room and placed the bottle on the dresser. Observations revealed the stock cranberry tablet bottle was placed on Resident #3's dresser without a barrier and without cleaning/disinfecting the surface where the stock medication bottle was placed. RN #225 opened the bottle and poured two tablets into a medication cup and replaced cap. RN #225 administered the medication to the resident and exited the room. RN #225 returned to the medication cart and placed the bottle of cranberry tablets into the medication cart along with other resident medications without cleaning/disinfecting the bottle.</p> <p>Interview on 05/08/24 at 11:31 A.M. with RN #225 verified she did not clean the multidose bottle of cranberry tablets before placing them back into the medication cart with the other over the counter medication bottles.</p> <p>2. Medical record review for Resident #22 revealed an admitted [DATE] with diagnoses including but not limited to Alzheimer disease, dementia, hypertension, hypothyroidism, hyperlipidemia, major depressive disorder, dorsalgia, macular degeneration, migraine, and anxiety.</p> <p>Review of the quarterly MDS assessment dated [DATE] for Resident #22 revealed an intact cognition. Resident #22 required supervision for eating, bed mobility and transfers. Resident #22 required moderate assistance for toileting.</p> <p>Review of the active physician orders for Resident #22 revealed the resident had the following medications scheduled for morning administration: Tylenol Oral Tablet 325 mg give two tablets by mouth two times a day, B-Complex oral tablet give one capsule by mouth one time a day, Senna Plus tablet 8.6-50 mg give 1 tablet by mouth one time a day, zinc tablet 50 mg give 50 mg by mouth two times a day, vitamin D capsule give 1000 units by mouth one time a day.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/08/24 at 9:15 A.M. of RN #225 preparing medication for administration to Resident #22 revealed RN #225 carried facility stock bottles of B-complex, Senna Plus, Vitamin D, Tylenol and Zinc into the resident's room and set them on the bedside table without a barrier and without cleaning the bedside table. RN #225 then completed hand hygiene and donned gloves, poured prescribed medication from each bottle into a medication administration cup and offered it to the resident. RN #225 then completed hand hygiene and returned to the resident's bedside. RN #225 then placed the contaminated gloves she had removed prior to completing hand hygiene onto the top of the Tylenol multidose bottle. RN #225 donned gloves and administered the artificial tears eye drops into both eyes of Resident #22. RN #225 went to the residents bathroom and completed hand hygiene returning to the residents bedside with a second set of contaminated gloves. RN #225 retrieved the plastic cup that had contained water for the resident to take her medication with and put the second pair of gloves into the cup, picked up the contaminated gloves from the top of the Tylenol bottle and placed them in the cup. RN #225 then carried the five bottles in her left arm touching her uniform and returned to the medication cart. RN #225 then disposed of the cup with the gloves in it, and placed the bottles on the cart without cleaning/disinfecting them. RN #225 then placed all five bottles back into the medication cart with other resident medications without cleaning/disinfecting them.</p> <p>Interview on 05/08/24 at 9:30 A.M. with RN #225 stated she did not dispose of the gloves into the residents trash bin in the bathroom because there was nothing in the trash bin and she did not want to leave trash in the residents room. RN #225 verified she placed contaminated gloves on the top of the Tylenol bottle and should not have. Further verified she does not know the policy for the facility related to the multidose bottles being taken into residents rooms.</p> <p>Interview on 05/08/24 at 1:35 P.M. with Director of Nursing (DON) verified that multidose bottles of medication should not be carried into the residents rooms. Additionally, verified that gloves should be placed in to the appropriate trash receptacle in the resident bathroom when appropriate.</p> <p>Request for a policy related to medication administration related to multidose bottles was requested during the survey and was advised by the DON that the facility did not have a policy.</p> <p>The following deficiency is based on incidental findings discovered during the course of this complaint investigation.</p>		