STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365551	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLOVERNOOK HEALTH CARE AND REHABILITATION CENTER	**7025 CLOVERNOOK AVENUE CINCINNATI, OH 45231**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop a comprehensive plan of care related to pressure ulcers. This affected one (#3) of three residents reviewed for wounds/pressure ulcers. The facility census was 82. Findings include: Review of the record for Resident #3, revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. On 04/16/20, a [DIAGNOSES REDACTED]. Review of the admission nursing assessment identified the resident was admitted with a Stage 3 pressure ulcer to the sacral region. Review of the comprehensive admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had impaired cognition. The resident was extensive assistance of two staff for bed mobility, transfers, and was non-ambulatory. The assessment indicated the resident had a Stage 3 pressure ulcer. Review of the initial comprehensive plan of care revealed the stage three pressure ulcer had not been addressed. On 07/07/20 at 9:27 A.M., an interview with Registered Nurse (RN) #30 verified no skin issues had been addressed in the initial comprehensive plan of care.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.