STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365045	A. Building B. Wing	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillebrand Nursing and Rehabilitation Center	4320 Bridgetown Road Cincinnati, OH 45211

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 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** 39702 Based on medical record review, staff interviews and policy review, the facility failed to obtain additional instructions/orders from the physician when a vacuum-assisted closure (wound vac) was not available and/or not applied as ordered. Additionally, the facility failed to obtain instructions/orders to provide care for a residents peripherally inserted central catheter (PICC) line. This affected one (#130) of three reviewed for quality of care. The facility census was 103. Findings include 1. Review of the medical record for Resident #130 revealed an admitted [DATE] and a transfer to the hospital on 10/13/23. Diagnoses include surgical aftercare following surgery on the digestive system, ulcerative colitis with complications, rectal abscess, ileostomy, moderate protein calorie malnutrition, depression, hypokalemia, ileus, and hypothyroidism. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #130 revealed the resident had an intact cognition. Resident #130 was coded with rejection of care one to three days during the assessment period. Resident #130 required set up assistance with eating and extensive assistance with transfers, bed mobility and toileting. Resident #130 was coded with a surgical wound. Review of the plan of care for Resident #130 was in progress. Review of the physician orders for Resident #130 dated 10/09/23 revealed an order to change wound vac to rectal abscess area every Tuesday, Thursday and Saturday on day shift. Review of the Treatment Administration Record (TAR) for Resident #130 for October 2023 revealed wound vac was not applied on the 10/10/23 as ordered. Further review of the TAR revealed the wound vac was applied on 10/11/23. Review of the nurse's progress notes dated 10/09/23 and 10/10/23 for Resident #130 contained no documentation for physician notification of wound vac not being applied as ordered. Review of the progress notes for Resident #130 dated 10/11/23 at 11:03 A.M. revealed the resident's wound vac was placed on this day. Resident #130 tolerated procedure well. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/23 at 10:10 A.M. with the Administrator stated Resident #130 had initially refused the wound vac at the hospital so when she was admitted it was ordered and was told it would ship overnight from the supplier. Due to Resident #130's late arrival, it was not shipped until the 10/10/23 and arrived at the facility on 10/11/23. Interview on 11/14/23 at 1:45 P.M. with the Director of Nursing (DON) and the Unit Manager Licensed Practical Nurse (LPN) #22 verified the physician was not notified of the delay in application of the wound vac and should have been. Additionally, the DON and Unit Manager LPN #22 verified there was not an order for a wet to dry dressing until the wound vac arrived. Interview on 11/14/23 at 2:16 P.M. with Nurse Practitioner (NP) #200 verified both perineal wound and abdominal wound were draining malodorous drainage. NP #200 stated she was not notified of the delay in wound vac placement. 2. Further review of the nurse's admission note for Resident #130 dated 10/09/23 revealed resident had a PICC that flushes easily and was patent (operational). Review of the physician orders for Resident #130 revealed there were no orders or instructions related to the PICC line. Review of the Medication Administration Record (MAR) for the month of October 2023 revealed there was no documentation regarding monitoring, dressing changes or flushes to PICC line. Interview on 11/14/23 2:16 P.M. with NP #200 verified the PICC line was in place when Resident #130 had her follow up appointment on 10/13/23 and further stated it was not placed during the appointment with her. Interview on 11/14/23 at 3:12 P.M. with LPN #2 states she started the admission assessment for Resident #130 and confirmed a PICC line was present on admission. LPN #2 stated she did not fully complete Resident #130's assessment so another LPN at the facility took over at the change of shift. Interview on 11/14/23 at 4:45 P.M. with the DON and Unit Manager LPN #22 verified the medical record contained no orders, treatments or monitoring for Resident #130's PICC line. Review of the facility policy titled Flushing Intravenous Access Devices undated stated to check physicians order noting flushing solution and amounts. The policy further states a PICC line should be flushed every 12 hours. This deficiency represents non-compliance investigated under Complaint Number OH00147507.