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No. 0938-0391

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	06/28/2024

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 42731 Based on medical record review, observation, review of facility in-service records, review of a personnel file, review of the safety inspection bus checklist, review of the facility's Self-Reported Incidents (SRIs), review of facility policies, review of the emergency medical services (EMS) run report, review of hospital documentation, resident interview, and staff interview, the facility failed to ensure a resident was safely secured in the wheelchair with an appropriate seat belt during transportation in a facility bus from an activity department outing. This resulted in Immediate Jeopardy when one resident (#05) was placed at potential risk for serious life-threating harm and/or injuries when on 05/28/24, Activity Director (AD) #300 abruptly stopped the facility bus, causing Resident #05 to fall forward out of his wheelchair, hitting another resident, and then landing on the floor. During the fall, Resident #05 sustained a degloving/laceration (a traumatic injury that results in the top layers of skin and tissue being torn away from the underlying muscle, connective tissue or bone) to his right lower leg, requiring 35 sutures, and a right chest contusion near his chemotherapy port-a-cath port. AD #300 pulled over and, with the help of Activities Assistant (AA) #315, attempted to lift Resident #05 off the floor of the bus. When they were unable to lift Resident #05, they summoned assistance from EMS, who arrived and transported Resident #05 to the emergency room (ER) for treatment. Resident #05 was treated in the ER and sent back to the facility with orders for antibiotics. On 06/01/24, four days following the bus accident, Resident #05 complained of chest pain with movement and pain, redness, warmth, and swelling to the open area on his right lower extremity. Resident #05 was sent to the hospital, admitted for cellulitis of the right leg, and remained in the hospital for four days for intravenous (IV) antibiotic treatment. This affected one (Resident #05) of three residents reviewed for use of assistive devices during transportation. The facility identified a total of 52 residents who utilized a wheelchair and the facility transportation. The facility census was 99. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/13/24 at 11:29 A.M., the Administrator was notified that Immediate Jeopardy began on 05/28/24 at approximately 2:15 P.M. when Resident #05 was placed in the facility bus, with his wheelchair secured to the floor of the bus, but with no seatbelt to secure the resident into the wheelchair. AD #300 abruptly stopped the facility bus, causing Resident #05 to fall forward out of his wheelchair, hitting another resident, and then landing on the floor of the bus. During the fall, Resident #05 sustained a degloving/laceration to his right lower leg, requiring 35 sutures, and a right chest contusion near his chemotherapy port-a-cath port. AD #300 pulled over and, with the help of AA #315, attempted to lift Resident #05 off the floor. When they were unable to lift Resident #05, they summoned assistance from EMS, who arrived and transported Resident #05 to the ER for treatment. Resident #05 was treated in the ER and sent back to the facility on antibiotics. On 06/01/24, Resident #05 complained of chest pain with movement and pain, redness, warmth, and swelling to the open area on his right lower extremity. Resident #05 was sent to the hospital, admitted for cellulitis of the right leg, and remained in the hospital for four days for intravenous (IV) antibiotic treatment. The Immediate Jeopardy was removed on 05/31/24 at approximately 12:45 P.M. when all education was completed for staff, which included that the transportation bus was not to be driven, and competency checks were completed on staff that were authorized to drive the other facility vehicle, which was the transport van, by ensuring proper securing of residents during transport. The deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was verified as corrected on 06/28/24 when the facility implemented the following corrective actions: On 05/28/24 at 2:45 P.M., AD #300 notified Assistant Director of Nursing (ADON) #320 of the incident on the facility bus involving Resident #05. On 05/28/24 at approximately 2:45 P.M., ADON #320 notified the DON of the incident on the facility bus involving Resident #05. On 05/28/24 at 2:50 P.M., ADON #320 and the DON notified the Administrator of the incident on the facility bus involving Resident #05. On 05/28/24 at approximately 3:00 P.M., the Administrator interviewed Transportation Driver (TD) #335 regarding the procedure for bus outings. He was not on the outing on the facility bus in which Resident #05 was injured. On 05/28/24 at approximately 3:00 P.M., Licensed Practical Nurse/Unit Manager (LPN/UM) #350 notified Resident #05's representative by phone regarding the incident. On 05/28/24 at approximately 3:30 P.M., the Administrator, the DON, and ADON #320 interviewed AD #300, upon her return to the facility, following the incident on the facility bus involving Resident #05. On 05/28/24 at approximately 3:45 P.M., the Administrator left a voice message for the Director of Transportation (DOT) #330 to return her call. On 05/28/24 at approximately 3:50 P.M., the Administrator interviewed Maintenance Director (MD) #325 regarding safety check procedures for the facility vehicles. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/28/24 at 4:00 P.M., the Administrator issued a directive for the facility bus (the vehicle in use during the incident involving Resident #05) and the facility van to not be used until further notice. On 05/28/24 at 4:00 P.M., involved parties, AD #300, DOT #330, MD #325, and TD #335 were put on suspension pending the outcome of the investigation. On 05/28/24 at 4:00 P.M., Unit Clerk (UC) #355 started calling transportation companies to make arrangements for upcoming appointments already scheduled for the current week and the following week as the Administrator had issued the directive for staff not to use the bus or the van until further notice. On 05/28/24 at approximately 4:30 P.M., a safety meeting was held with the Administrator, DON, ADON #320, LPN/UM #350, and Compliance Officer (CO) #345. Topics of the safety meeting included the following: the incident which occurred on 05/28/24 in the facility bus for Resident #05, education to be performed as a follow-up to the incident, who needed to be educated, taking the facility vehicles out of service temporarily, and delegated procedures to be completed. On 05/28/24 at approximately 5:00 P.M., the facility initiated an SRI with the Ohio Department of Health (ODH). On 05/29/24 at 9:00A.M., CO #345 created education for TD #335, DOT #330, MD #325, Maintenance Assistant (MA) #305, and AD #300. On 05/29/24 at 9:00 A.M., the DON created a nursing education packet. On 05/29/24 at 9:00 A.M., CO #345 developed an auditing system for the facility van and reviewed and updated the inspection checklist and competency skill list for drivers and maintenance staff. On 05/29/24 at 11:00 A.M., the DON, LPN Supervisor #360, and State tested Nursing Assistant (STNA) #365 began in-servicing staff regarding gait belts and abuse, neglect and misappropriation. The education was completed on 05/31/24 at approximately 5:30 P.M. On 05/29/24 at approximately 11:45 A.M., the Administrator, DON, ADON #320, and CO #345 interviewed DOT #330 via telephone. On 05/29/24 at approximately 2:00 P.M., a safety meeting was held with the Administrator, DON, ADON #320, LPN/UM #350, CO #345, and MA #305. At the meeting staff reviewed the status of the education and training following the incident. Facility management decided TD #335 and MD #325 would return to work on 05/31/24 and would be educated on 05/31/24 at 11:00 A.M. prior to resuming their work duties. On 05/31/24 at 9:00 A.M., TD #335 and MD #325 returned to work. On 05/31/24 from 11:00 A.M. to 1:00 P.M., CO #345 educated TD #335, MD #325, and MA #305. The education included the following: viewing a vehicle safety video, reviewing and signing education packets, review of competency, vehicle checklists and audit forms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/31/24 at approximately 12:45 P.M., MA #305, who had prior transportation knowledge from previous employment, performed competency checks on the facility van with assistance from ADON #320 and LPN/UM #350. Beginning on 06/01/24 at approximately 10:00 A.M., TD #335 began audits of the facility van and MA #305 signed off on the audits. The audits were to be completed on days of driving the van, prior to driving the van, daily for two weeks, then three times per week for two weeks, and then monthly thereafter. On 06/03/24 at 8:21 A.M., ODH requested additional information regarding the SRI. The facility sent the requested information to ODH at approximately 12:00 P.M. On 06/03/24 at 12:15 P.M., the Ohio State Highway Patrol (OSHP) inspected the facility bus, and the bus passed the inspection. On 06/03/24 at 3:00 P.M., CO #345 reviewed and updated the policy regarding transportation drivers and outings. The updates to the policy included staff would bring information regarding resident's code status on the outing and the driver of the vehicle would complete a final walk-through safety check of the residents before driving off. On 06/13/24 at 3:00 P.M., MA #305 educated employees permitted to drive the facility bus (MD #325 and TD #335) on how to properly secure residents into the facility bus. MA #305 LPN/UM #350, and ADON #320 completed facility bus competencies with MD #325 and TD #335. Competencies will be completed on all authorized drivers for all facility vehicles quarterly. Beginning on 06/14/24 facility bus audits were initiated. TD #335 will perform these audits Monday through Friday every day for 2 weeks, then 3 times a week for 2 weeks, and then monthly thereafter. Interviews on 06/17/24 between 4:15 P.M. and 4:30 P.M. with TD #335 and MD #325 confirmed they were educated on the facility van on 05/31/24 and educated on the facility bus on 06/13/24. On 06/28/24 between 8:22 A.M. and 9:10 A.M., observations, review of facility audit records, and interviews with TD #335, MD #325 and MA #305 were conducted. TD #335 was observed conducting the daily audit on the facility bus and van. TD #335 confirmed he has been completing audits of the bus and van daily on days worked (Monday-Friday). Review of the audits revealed they had been completed as indicated through 06/28/24 and no further issues were identified. TD #335 stated part of his daily audit is to check the mileage of each vehicle. TD #335, MD #325, and MA #305 confirmed the bus had not been driven since 06/03/24, when it was taken to the OSHP for inspection. The bus remains out of service. Findings include: Review of the medical record for Resident #05 revealed an admitted [DATE] with diagnoses including, morbid obesity, cirrhosis of liver, dementia, chronic atrial fibrillation, bradycardia, malignant neoplasm of vertebral column and kidney, congestive heart failure, peripheral vascular disease, depression, anxiety, and vascular dementia. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the comprehensive Minimum Data Set (MDS) assessment for Resident #05 dated 04/20/24 revealed the resident had intact cognition and required supervision or touching assistance for bed mobility, transfers and ambulation. Resident #05 utilized a walker and wheelchair for mobility. Review of the prehospital care report summary (ambulance run report) for Resident #05 dated 05/28/24 revealed medics were dispatched on 05/28/24 at 2:23 P.M. for a person injured in a fall. Resident #05 was noted with an avulsion (pulling or tearing away) injury to the right lower leg. Resident #05 was noted stuck in a position with both legs under him under the wheelchair in front of him and his wheelchair stuck behind him and latched into place. Resident #05's wheelchair and multiple tie down points for the wheelchair had to be removed to access and extricate the resident. Once removal began, the resident slid backwards and a large skin tear on his lower right leg was observed. Medics bandaged the wound with a blood stopper and bleeding was controlled. Resident #05 was removed from the facility bus on the scoop stretcher and taken to the ER. Review of the hospital ER after visit summary for Resident #05 dated 05/28/24 revealed the resident was diagnosed with a large complex right leg laceration, a left knee contusion, and a right chest wall contusion. The laceration on the right leg measured 25 centimeters (cm.) in length and required 35 sutures. Following the laceration repair, a piece of skin was noted to be missing from the superior aspect of the wound. The missing piece of skin was found crumpled within Resident #05's sock, but it was completely devitalized and not able to be replaced. Resident #05 was given IV antibiotics in the ER and was prescribed oral antibiotics upon his return to the facility. Review of a nursing progress note for Resident #05 dated 05/28/24 at 6:49 P.M. revealed the activities department called ADON #320 and informed her Resident #05 fell from the wheelchair in the facility bus while returning from an outing. Resident #05 was noted to be on his knees with his legs under his wheelchair and fell forward and into the resident sitting in a wheelchair in front of him. The facility transport vehicle was pulled into a parking lot and nine-one-one (911) was called. EMS arrived and transported Resident #05 to the ER. Review of the SRI dated 05/28/24 revealed Resident #05's representative alleged neglect when the resident flew out of his wheelchair and was pinned under the chair in front of him. Resident #05's representative said if the resident had been secured, the incident would not have happened. The incident was described as follows: on 05/28/24, while returning from an activity outing, Resident #05 fell out of his wheelchair on the bus, into another resident. The bus was moved to a safe location. Staff were unable to assist Resident #05 up from the floor, so they called 911 and the resident was assisted from the floor to a stretcher and transferred to the hospital. An emergency safety meeting was conducted, and all involved staff were interviewed. Resident #05 was assessed at the ER and returned to the facility at approximately 10:00 P.M. on 05/28/24. The facility did not substantiate the allegation of neglect. Review of a nursing progress note for Resident #05 dated 05/29/24 at 1:59 A.M. revealed the resident returned from the hospital via ambulance. Review of a nursing progress note for Resident #05 dated 06/01/24 at 4:00 P.M. revealed Resident #05 complained of chest pain with movement and pain, redness, warmth, and swelling to the open area on the right lower extremity. The physician gave an order to transport Resident #05 to the hospital. EMS transported Resident #05 to the hospital and the resident's representative accompanied him. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nursing progress note for Resident #05 dated 06/01/24 at 11:43 P.M. revealed the resident was admitted to the hospital for cellulitis of the right leg. Review of the hospital continuity of care and after visit summary for Resident #05 dated 06/05/24 revealed the resident was admitted to the hospital on 06/01/24 for cellulitis of the right lower extremity. Resident #05 required IV antibiotics for methicillin-resistant staphylococcus aureus (MRSA) infection to the wound the resident sustained during the accident in the facility bus on 05/28/24. Review of a nursing progress note for Resident #05 dated 06/05/24 at 2:57 P.M. revealed Resident #05 returned to the facility from the hospital. Review of the employee file for AD #300 revealed a hire date of 11/03/03. AD #300 completed a road test checklist on 06/02/06 and an employee driver training on 06/07/06. AD #300's employee file did not include driver training after 2006. AD #300 resigned from her position effective 06/12/24. Review of the driver/vehicle examination report and bus safety inspection report per the OSHP dated 06/03/24 revealed the facility bus passed the safety inspection. Interview on 06/12/24 at 9:10 A.M. with Resident #05 confirmed on 05/28/24 he went on an outing to a local restaurant in the facility bus along with seven or eight other residents. Resident #05 confirmed some residents were sitting in bus seats, and there were four residents, including himself, in wheelchairs.? Resident #05 stated he was sitting in his wheelchair in the back of the bus, next to the lift.? Resident #05 stated the staff had fastened his wheelchair to the floor of the bus, but no one had applied a seat belt to secure him into the wheelchair itself. Resident #05 further confirmed that as the bus pulled out of the restaurant to return to the facility, the driver hit the brakes suddenly and he fell forward out of his wheelchair and his right chest hit the wheelchair of the resident in front of him.? Resident #05 stated the other resident was on top of him and his legs were bent back behind him.? Resident #05 confirmed he repeatedly asked the driver (AD #300) to pull over, but she told him there was no place to pull over.? Resident #05 stated she finally pulled over in a parking lot and called EMS.? Resident #05 stated EMS got him out from under the other resident's wheelchair and transported him to the hospital.? The resident stated he was treated and released from the hospital and then ended up in the hospital for four days for IV antibiotics.? Interview on 06/12/24 at 11:17 A.M. with AA #315 confirmed on 05/28/24 he was riding near the front of the bus on a facility outing when the bus came to a sudden stop, and he heard Resident #05 say he was in pain. AA #315 stated he turned around and saw Resident #05 had slid out of his wheelchair and was on the floor of the bus. AA #315 stated he alerted the driver, AD #300, but it was a few minutes before the driver was able to pull over into a parking lot. AA #315 stated Resident #05 was on his knees, with his chest pressed up against the wheelchair in front of him. AA #315 stated there were four wheelchairs on the bus and all four wheelchairs remained in the upright position and secured when the bus came to a sudden stop. AA #315 confirmed Resident #05 was not secured into his wheelchair by a seat belt or any type of chest restraint when the bus stopped suddenly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/12/24 at 1:39 P.M. with AD #300 confirmed on 05/28/24, she and AA #315 took eight residents on an activity outing to a local restaurant for lunch. AD #300 stated after lunch she loaded everyone on the bus, including Resident #05 who was placed in the spot without a seatbelt. AD #300 confirmed sometimes they used a gait belt in that spot without a seat belt. AD #300 confirmed she did not restrain Resident #05's body into the wheelchair with anything on the way back from lunch on 05/28/24. AD #300 stated, on the day of the incident, she was driving and slowed down for traffic when AA #315 told her Resident #05 was on the floor of the bus. AD #300 stated as soon as it was safe she pulled over, and she and AA #315 attempted to lift Resident #05 off the floor of the bus. When they were unable to lift Resident #05, they called 911 and waited for EMS to arrive. AD #300 confirmed at the time of the incident, she was told a new seatbelt would be ordered and had previously been told she could use a gait belt to restrain residents in the fourth wheelchair spot, since there was not a seatbelt. AD #300 stated DOT #330 told her a year or two ago he was going to order a new harness/seatbelt and told her to use the gait belt until it arrived. AD #300 stated DOT #330 told her the previous administrator told him he could use a gait belt instead. AD #300 stated she was trained to drive the bus when the facility first got the bus back in 2006 but had not received any further training or competency checks. Interview on 06/12/24 at 2:15 P.M. with the Administrator confirmed she was unaware there was not a fourth seatbelt in the facility bus. The Administrator stated, following the incident, she learned the previous administrator had instructed staff to use a gait belt since there was no seatbelt in the fourth wheelchair spot. The Administrator confirmed the use of a gait belt in place of a seatbelt was not an appropriate practice. The Administrator stated, following the incident, DOT #330, AD #300, MD #325, and TD #335 were suspended. MD #325 and TD #335 were permitted to return to work on 05/31/24 as they were not present the day of the incident. The Administrator stated DOT #330 was responsible for overseeing the use of the bus and keeping everyone who was permitted to drive the facility vehicles up to date on safety measures. The Administrator stated facility vehicle competencies with return demonstration were completed with employees trained to drive facility vehicles using the facility van following the incident. Interview on 06/12/24 at 2:30 P.M. with DOT #330 confirmed he replaced the seatbelts in the bus approximately three years ago and stated there was another seatbelt on order at the time of the incident on 05/28/24 involving Resident #05. DOT #330 stated he was not sure when the fourth seatbelt for the bus came up missing. DOT #330 stated he ordered a replacement seatbelt approximately two years ago and installed the seatbelt with TD #335. DOT #330 stated the previous administrator allowed staff to use gait belts to restrain residents if the seatbelts were unavailable or not working. Interview on 06/12/24 at 2:53 P.M. with the Administrator confirmed she instructed staff not to use the facility bus or the facility van until further notice. The Administrator confirmed the facility was trying to decide if they could get a new bus because it required frequent repairs or if they might resume use of the bus involved in the incident with Resident #05. The Administrator confirmed the root cause of the incident involving Resident #05 had nothing to do with any mechanical failures of the bus. The Administrator confirmed the root cause of the incident causing injury to Resident #05 was AD #300's failure to properly secure Resident #05 in his wheelchair on the bus. Interview on 06/13/24 at 11:32 A.M. with the Administrator confirmed the education which included competencies and return demonstrations provided to drivers of the facility vehicles on 05/31/24 was completed using the facility van. The Administrator confirmed the staff had not been educated on using the facility bus which was the vehicle in use during the incident with Resident #05 on 05/28/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/13/24 at approximately 12:00 P.M. with TD #330 confirmed DOT #335 had trained him in the past to use a gait belt as a substitute for the seat belt for the spot in the facility bus without a restraint. TD #330 confirmed he was unsure if this was a safe practice, but he did not report his concerns to the current facility Administrator. Observation on 06/13/24 at 12:05 P.M. of the facility bus (the vehicle in use at the time of the incident involving Resident #05) with TD #330 and MA #305 revealed the staff demonstrated how they used straps from two different restraint systems in order to be able to restrain three residents in wheelchairs prior to driving the bus. There was a fourth wheelchair seat in the bus which did not have any type of seatbelt or restraint. Interview on 06/13/24 at 12:10 P.M. with TD #330 and MA #305 confirmed the fourth wheelchair seat in the bus had no seatbelt or restraint. Further interview confirmed AA #315 told them Resident #05 had been sitting in the fourth wheelchair spot, which had no seatbelt or restraint when the resident was injured on 05/28/24. Review of the facility policy titled Activity Outings dated 06/01/24 revealed staff should secure residents in the vehicle before driving using an appropriate restraint or seat belt. The driver should conduct a final walk-through inspection to ensure everyone was properly secured before leaving for the destination. This deficiency represents noncompliance investigated under Complaint OH00154499 and Complaint OH00154442.