

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Hillebrand Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702</p> <p>Based on medical record review and staff interviews, the facility failed to ensure resident's medical record contained documentation for completed care and services provided by staff. This affected one (#216) out of three residents reviewed for quality of care. The facility census was 103.</p> <p>Findings included</p> <p>Review of the medical record for Resident #216 revealed an admitted [DATE] and a discharge home on [DATE] with private care givers and hospice. Resident #216 expired in the home on [DATE]. Diagnoses included Alzheimer's disease with late onset, dementia with agitation and anxiety.</p> <p>Review of the discharge Minimum Data Set (MDS) assessment for Resident #216 dated [DATE] was not completed at the time of the survey.</p> <p>Review of the baseline plan of care for Resident #216 dated [DATE] revealed the resident was admitted to nursing facility for a respite due to Alzheimer's disease. Interventions include use of my personal preferences to help develop plans of care and daily routine, manage all activities of daily living (ADL) supports, incontinence, medication and risks.</p> <p>Review of physician orders for Resident #216 revealed an order for a mechanical soft diet with mechanical soft texture and thin consistency, requires feeding assistance, cues, encouragement, send one to two finger foods per meal for diet type dated [DATE].</p> <p>Review of the electronic health record (EHR) for the certified nursing assistant (CNA) documentation for Resident #216 dated [DATE] to [DATE] revealed two entries for percentage of meal consumed on [DATE]. The documentation contained one meal consumed at fifty percent to seventy five percent and one meal consumed at twenty six percent to fifty percent. The remaining dates during the time frame contained no documentation for percentage consumed.</p> <p>Review of the EHR for the CNA documentation for Resident #216 dated [DATE] to [DATE] titled ability to roll from lying on back to the right and left side five revealed five entries. There was no documentation for turning and repositioning on [DATE] and [DATE]. On [DATE], [DATE], [DATE] there was only one entry for the care provided and there should have been two. The CNA's document the one time on a twelve hour shift indicating they have turned and repositioned the resident every two hours.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the EHR for the CNA documentation for Resident #216 dated [DATE] to [DATE] titled intake and output revealed five entries. There was no documentation for any oral fluid intake on [DATE] and [DATE]. On [DATE] at 1:41 A.M., [DATE] at 11:35 P.M. , [DATE] at 12:05 A.M. revealed was only one entry for 120 cubic centimeters (cc) of intake daily.</p> <p>Interview on [DATE] at 1:21 P.M. with the Director of Nursing (DON), verified the CNA documentation for Resident #216 was not completed as it should have been.</p> <p>Interview on [DATE] at 2:40 P.M. with the Administrator verified the lack of documentation related to turning and repositioning, meal intakes and intake and output of fluid for Resident #216.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163136.</p>