STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366134	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARDIN HILLS HEALTH CENTER	1211 W LIMA ST KENTON, OH 43326

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 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, medical record review, and review of facility policy, the facility failed to ensure timely placement of a hearing aid for a resident. This affected one resident (Resident #4) of one resident reviewed for communication and sensory. This had the potential to affect eight residents identified as utilizing hearing aids. Findings include: Review of Resident #4's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #4's Minimum Date Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #4 had moderate difficulty with hearing and utilized a hearing aid as an assistive device. Review of Resident #4's physician order [REDACTED]. Review of Resident #4's care plan revised 12/19/19 revealed Resident #4 had a potential communication problem due to bilateral sensorineural hearing loss with an intervention for a hearing aid to be monitored, applied, and removed by nursing staff. The hearing aid was to be stored in the medication cart and if Resident #4 removed the hearing aid on her own, the hearing aid would be given to the nurse. Staff were also responsible for changing the batteries as needed. Interview on 03/09/20 at 9:58 A.M. with Resident #4 revealed the resident was hard of hearing and wanted her hearing aid. During the interview, hearing aids were not observed to be in either of Resident #4's ears and the resident repeatedly asked for comments and questions to be repeated. Resident #4 stated she did not know where her hearing aid was. Observations on 03/09/20 at 9:52 A.M. and 1:34 P.M. revealed Resident #4 sitting in her room. Hearing aids were not observed in either of Resident #4's ears. Interview on 03/09/20 at 1:34 P.M. with Resident #4 stated she was hard of hearing and stated staff had not placed her hearing aid in and she did not know where it was. Interview on 03/10/20 at 1:51 P.M. with Registered Nurse (RN) #200 confirmed Resident #4 had a hearing aid. RN #200 stated she had not worked in Resident #4's hallway in a few weeks and was unsure if Resident #4 kept her hearing aid in her room or if the hearing aid was stored in the nursing cart, but felt Resident #4 had previously stored the hearing aid in her room. RN #200 reviewed the physician order [REDACTED].#4's care plan revised 12/19/19 and confirmed the two were inconsistent leading to confusion of where the hearing aid was to be stored and who was responsible for the insertion and removal of the hearing aid. During the interview, RN #200 made an observation of Resident #4 and confirmed Resident #4 did not have her hearing aid in. RN #200 had to yell in Resident #4's right ear in order for Resident #4 to understand. Resident #4 gave consent for RN #200 to look around her room for the hearing aid, but Resident #4 stated she did not know where the hearing aid was and she did not believe it was in her room. RN #200 was unable to locate the hearing aid in Resident #4's room and subsequently found it in the nursing cart in a box with Resident #4's name written on the top. RN #200 confirmed she assumed Resident #4 already had her hearing aid placed so RN #200 signed off on the Treatment Administration Record (TAR) confirming Resident #4 had her hearing aids inserted. RN #200 further confirmed she had not offered Resident #4 her hearing aid because RN #200 assumed it was inserted. Observation on 03/10/20 at 3:55 P.M. revealed Resident #4 was sitting in her room with a hearing aid inserted into her right ear. Resident #4 verified she had her hearing aid inserted and was able to hear better. Interview on 03/10/20 at 5:18 P.M. with the Director of Nursing (DON) confirmed Resident #4's physician order's dated 02/25/14 and care plan revised 12/19/19, did not match. The DON further confirmed the order needed to be updated because Resident #4 was no longer able to care for her hearing aid and needed assistance from staff to store, insert, and remove them.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure a resident's physician ordered fluid restriction was adequately implemented. This affected one (Resident #322) of one resident reviewed for fluid restrictions. The facility identified two residents on fluid restrictions. The facility census was 71. Findings include: Review of Resident #322's medical record revealed an admission date of [DATE]. Medical [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Review of the resident's baseline care plan dated 03/06/20 revealed Resident #322 was at risk for exacerbation of [MEDICAL CONDITION] with a nutritional fluid restriction of 2000 ml. Interview on 03/10/20 at 2:00 P.M. with the Director of Nursing (DON) confirmed the physician order [REDACTED].#322 as of 03/10/20. Review of Resident #322's Treatment Administration Records (TAR) for March 2020 revealed a fluid restriction to have been implemented on 03/10/20 of documented fluid intakes with medication passes. Interview on 03/10/20 at 2:20 P.M. with Cook #520 revealed no knowledge of Resident #322 being on a fluid restriction. Interview on 03/10/20 at 2:25 P.M. with Licensed Practical Nurse (LPN) #310 revealed knowledge of Resident #322 having an order for [REDACTED].M. with LPN #310 revealed contacting the dietary manager who informed LPN #310 that dietary will be providing 500 ml with each meal and nursing will be provided 500 ml with mediation passes. Review of a physician order [REDACTED].M. revealed Resident #322 to have an order for [REDACTED].M. with Dietitian #530 revealed that nursing provides the breakdown of fluid restrictions and the dietitian provides suggestions for the fluid breakdown. Dietitian #530 reported a recommendation on 03/12/20 of 1460 ml's for dietary services and nursing provisions of 540 ml's of fluid each day. Review of a facility provided undated document titled Forcing and Restricting Fluids, undated, revealed the key procedural points to be inclusive of accurate recording of fluid intake, recording fluid intake in cc's, be supportive of resident's fluid intake and encourage resident to follow the specific instructions, encourage the resident's family and visitors to stay within the limits of the intake, remove the water pitcher and cup from the room, check the resident's care plan and daily assignment sheet and make sure an intake and output record in maintained in the resident's room.
F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, family interview, staff interview, dentist office interview, and facility policy, the facility failed to ensure a resident received dental services as requested. This affected one (Resident #11) of one resident reviewed for dental services. The facility census was 71. Findings Include: Review of Resident #11's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #11's medical record revealed no documentation the resident had been seen by a dentist since admission. Interview on 03/11/20 at 3:43 P.M. with Social Services Director #550 stated the dentist visited the facility on 01/16/20. Resident #11 was on the list to be seen by the dentist. Social Services Director #550 stated Resident #11's husband had given a check for dental services to Business Office Manager (BOM) #540. Interview on 03/11/20 at 4:06 P.M. with BOM #540 stated she sent a check for Resident #11 to the dentist office. BOM #540 was not able to provide a date the check was sent to the dentist office and did not make a copy of the check. Telephone interview on 03/11/20 at 4:45 P.M. to dentist office stated their office never received a check for Resident #11 to receive dental services. The dentist office verified the resident was not seen by the dentist on 01/16/20. Interview on 03/12/20 at 1:10 P.M. with Resident #11's husband stated he had given a check about four months ago to Social

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.

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F 0790 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Service Director #550 so that his wife could be seen by the dentist. The resident's husband stated BOM #540 told him she sent the check to the dentist office but the office never received the check. Resident #11's husband stated was going to have to stop payment on the check since the dentist never received the check. Review of facility policy titled Dental Services dated December 2016, revealed routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Based on staff interview, observation of laundry handling, and review of policies for infection control and laundry, the facility failed to ensure soiled linens were handled in a manner to prevent cross contamination. This had the potential to affect all residents. The census was 71. Findings include: Observation on 03/12/20 at 10:40 A.M. revealed Housekeeping Aide (HA) #560 was manually transferring soiled linens from a large wheeled bin, to a commercial-size washing machine, in the laundry room. HA #560 was wearing a short-sleeved t-shirt, pants, disposable gloves that also covered the wrists, and no protective gown. HA #560 transferred several arm loads of soiled linens from the bin to the machine, with each load coming into contact with HA #560's t-shirt. Interview with HA #560 during and immediately following this observation revealed the aide is assigned to housekeeping tasks routinely, but was covering laundry tasks on this date, as is done on occasion when staffing necessitates this change in assignment. HA #560 reported that upon hire and periodically, training was provided by the facility on infection control measures, including use of personal protective equipment (PPE), however, the aide did not recall training specific to use of a protective gown when necessary, while handling soiled laundry. HA #560 confirmed a gown was not in use and soiled linens came into contact with the aide's t-shirt while transferring the items prior to the interview. HA #560 further confirmed a possibility of cross contamination between the soiled linens and the t-shirt, since no protective gown was utilized. Observation during the interview revealed there were multiple disposable gowns in two separate locations in the laundry room, in addition to several non-disposable gowns hanging on a hook in a corner. Interview on 03/12/20 at 11:29 A.M. with the Director of Nursing (DON) confirmed staff are to wear a protective gown when handling laundry, when necessary to prevent cross contamination of pathogens between soiled laundry and the staff person's personal clothing. Review of a policy titled, Infection Control Policy, last revised 10/03/19, revealed staff shall use a disposable gown when at risk of coming into contact with body fluids. Review of a policy titled, Laundry and Linen, last revised April 2010, revealed all soiled linen should be considered potentially hazardous. The policy stated employees sorting or washing linens must wear a gown/apron, gloves, and a mask if aerosolization occurs.