STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365134	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Ridge Nursing & Rehabilitation Center	721 Hickory St Akron, OH 44303

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 ensure Resident #65's care plan clearly reflected interventions to be used for safe transfer. This affected one (#65) out of three residents reviewed for falls. The facility census was 147. Findings include: Clinical record review revealed Resident #65 was admitted on [DATE] with diagnoses including liver cancer, chronic bronchitis, aphasia, high blood pressure, heart failure, intermittent explosive disorder, dementia, anxiety, viral hepatitis, hyperlipidemia, ventral hernia, and intestinal obstruction. Review of Resident #65's plan of care initiated on 08/15/24 indicated Resident #65 was at risk for falls related to a diagnosis of impaired cognition, dementia, anxiety, pain, use of psychotropic medications, and medical conditions including unsteadiness on feet, abnormalities of gait and mobility, abnormal posture, dizziness and giddiness. Interventions on the plan of care included to ensure environment was free of clutter and maintain a clear pathway. On 11/18/24 an additional intervention was added to use a Hoyer lift for transfers (Hoyer is a brand name that includes many different types of lifts including manual lifts, power lifts, stand up lifts, overhead lifts, bath lifts, and pool lifts). The care plan was not specific to whether a mechanical lift, power lift, overhead lift or stand up lift should be utilized. Review of Resident #65's fall risk assessment dated [DATE] indicated Resident #65 had a high risk for falls. Review of Resident #65's health status note dated 11/18/24 indicated Resident #65 was assessed for safety in use of sit-to-stand mechanical lift. Resident #65 was assessed and participated in a transfer from a bed to a chair, demonstrating upright stance with feet in proper placement on base of lift, bilateral knees supported by leg support, sling secured in place around waist with use of blue loops on hooks. Resident #65 demonstrated safe hand placement on lift, and assisted to maintain upright stance during transfer. An interview on 01/28/25 at 3:20 P.M. with the Administrator and Regional Clinical Director confirmed the plan of care was revised on 11/18/24 for the use of a Hoyer lift for transfers instead of a sit-to-stand lift. Regional Clinical Director verified the health assessment indicated Resident #65 could safely transfer with the use of a sit-to-stand lift.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of the nursing assistant job description, the facility failed to ensure Resident #17 was consistently assisted with shaving his facial hair on a daily basis. This affected one (#17) out of three residents reviewed who were dependent of staff for assistance with their activity of daily living (ADL) needs. The facility census was 147. Findings include: Clinical record review revealed Resident #17 was admitted on [DATE] with diagnoses including multiple sclerosis, cerebral infarction (stroke), depression, transient ischemic attack (TIA), heart failure and dementia. Review of Resident #17's Minimum Data Set (MDS) assessment dated [DATE] indicated he had mild cognitive impairment. Review of Resident #17's plan of care initiated on 11/08/24 revealed Resident #17 could require assistance with ADLs and could be at risk of developing complications associated with decreased ADL self-performance. Fluctuations and/or decline expected due to progressive neurological disease (multiple sclerosis). Interventions on the plan of care indicated Resident #17 needed assistance with bathing, grooming including nails, shaving and hair grooming. An observation and interview with Resident #17 on 01/27/25 at 12:05 P.M. revealed Resident #17 had thick unshaven facial hair. Resident #17 stated he hated the facial hair and wanted assistance with shaving but the facility did not provide an electric razor or assist him routinely with shaving his facial hair. Resident #17 stated he had a diagnosis of multiple sclerosis and needed assistance with grooming. An interview with Certified Nursing Assistant (CNA) #153 on 01/27/25 at 12:50 P.M. revealed Resident #17 preferred an electric razor for shaving his facial hair but the facility only had disposable razors available to shave the residents' facial hair. CNA #153 stated Resident #17's facial hair was too coarse to shave with a disposable razor. Resident #17 informed CNA #153 he would like to have his facial hair shaved every day and she offered and provided Resident #17 the disposable razors to shave his facial hair. An observation and interview with Resident #17 on 01/28/25 at 9:20 A.M. revealed he had unshaved facial hair. Resident #17 stated he needed assistance with shaving his facial hair and a couple of days ago an aide (unnamed) had assisted him with shaving his facial hair. Resident #17 stated he was not provided the disposable razors to shave his facial hair and had not been assisted with shaving for the last few days. An interview with CNA #154 on 01/27/25 at 9:55 A.M. revealed she had assisted Resident #17 with shaving his facial hair two days ago. CNA #154 stated she was aware Resident #17 needed assistance with shaving his facial hair but did not have time to assist Resident #17 with shaving on a daily basis. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Assistant Job description revealed the nursing assistant was responsible for providing direct care to residents, assisting the clinical team in providing activities of daily living for the residents and worked under the supervision of a licensed nurse. The nursing assistant worked in accordance with facility policies and procedures and reported resident needs and concerns to a licensed nurse. The nursing assistant was responsible for assisting all responsible residents with activities of daily living (ADLs), including but not limited to feeding, bathing, dressing, transferring, ambulation, locomotion, personal hygiene, and toileting. This deficiency represents non-compliance investigated under Complaint Number OH00161220.

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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 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on record review, resident and staff interviews, and policy and procedure review, the facility failed to ensure the safe transfer of Resident #65 resulting in a fall and failed to maintain Resident #137's care planned interventions to prevent falls. This affected two (#65 and #137) of three residents reviewed for falls. The facility census was 147. Findings include: 1. Clinical record review revealed Resident #65 was admitted on [DATE] with diagnoses including liver cancer, chronic bronchitis, aphasia, high blood pressure, heart failure, intermittent explosive disorder, dementia, anxiety, viral hepatitis, hyperlipidemia, ventral hernia, and intestinal obstruction. Review of Resident #65's plan of care initiated on 08/15/24 indicated Resident #65 was at risk for falls related to a diagnosis of impaired cognition, dementia, anxiety, pain, use of psychotropic medications, and medical conditions including unsteadiness on feet, abnormalities of gait and mobility, abnormal posture, dizziness and giddiness. Interventions on the plan of care included to use a mechanical lift for transfers, ensure environment was free of clutter and maintain a clear pathway. Review of a fall investigation dated 11/17/24 revealed contributing factors of the fall included Resident #65's legs gave out. Certified Nursing Assistant (CNA) #152's witness statement revealed while attempting to transfer Resident #65 using a sit-to-stand lift, the lift tilted to one side and Resident #65 fell. Review of Resident #65's fall risk assessment dated [DATE] indicated Resident #65 had a high risk for falls. An interview with Resident #65 on 01/27/25 at 11:45 A.M. indicated he had a fall when an aide was assisting him out of bed using a sit-to-stand lift. Resident #65 stated while using the lift to transfer him back to bed the lift tilted and he fell on his buttocks on the floor. Resident #65 stated he had no injury except his bottom was sore for a few days. An interview with CNA #152 on 01/28/25 at 11:17 A.M. revealed CNA #152 was assisting Resident #65 to bed on 11/17/24 using the sit to stand lift. Resident #65 started to slide down due to weakness, the sit-to-stand lift tilted and he fell to the floor on his buttocks. CNA #152 stated the front wheel of the sit-to-stand lift was caught on a washcloth that was located under the bed which contributed to the lift tilting to the side. CNA #152 stated he was educated to have two staff assist when using the sit-to-stand lift to transfer a resident. Review of CNA #152's education document dated 11/18/24 indicated the Director of Nursing conducted the training. The training included ensuring the mechanical lift was working correctly and ensuring proper sweep of the floor to ensure it was free of clutter. The education indicated a washcloth was under the bed and caught on the wheel of the sit-to-stand lift causing the lift to tilt to one side. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/28/25 at 3:20 P.M. with Administrator and Regional Clinical Director verified the above findings. 2. Clinical record review revealed Resident #137 was admitted on [DATE] with diagnoses including diabetes mellitus, pulmonary disease, cerebral vascular disease, heart failure with a cardiac defibrillator implanted device, high blood pressure, atherosclerotic disease, peripheral vascular disease, cataracts with visual disturbances, thrombocytopenia, carpal tunnel syndrome of upper limbs, osteoarthritis, and breast cancer. Resident #137 had medical conditions including low back pain, unsteadiness on feet, muscle weakness, and abnormal gait, mobility and need for assistance with personal care. Review of Resident #137's plan of care initiated 12/05/23 indicated a risk of falls related to acute/unstable medical condition, stroke, debilitation, weakness, disease process, impaired balance, pain, history of falls, poor coordination, unsteady gait, and visual deficit. Interventions on the plan of care included to keep the bed in the lowest position, Call, don't fall sign, Dycem (non slip mat) to wheelchair, encourage and remind to ask for assistance, encourage resident to wear non-skid socks at all times when not wearing shoes, encourage resident to ask for assistance to get items out of closet, encourage resident to not do activity of daily living tasks while sitting on rollator, ensure call light is within reach, ensure environment is free of clutter, have commonly used articles within easy reach, maintain a clear pathway, new shoes provided to resident, non-skid strips next to bed, provide rest periods and resident to wear proper and non slip footwear. An observation of Resident #137's room on 01/27/28 at 2:00 P.M. and on 01/28/25 at 8:30 A.M. revealed there was no Dycem on Resident #137's wheelchair and there were no non-skid strips located on the floor beside Resident #137's bed. On 01/28/25 at 9:15 A.M. Certified Nursing Assistant (CNA) #150 verified there was no Dycem on Resident #137's wheelchair and there were no non-skid strips located on the floor beside Resident #137's bed. CNA #150 also verified Resident #137's plan of care to prevent falls had interventions including to place a Dycem to the wheelchair and non-skid strips should have been placed on the floor beside Resident #137's bed. An interview with Assistant Director of Nursing (ADON) #151 on 01/28/25 at 2:45 P.M. verified she was informed of the missing Dycem and non-skid strips in Resident #137's room to prevent falls and verified Resident #137's plan of care included these interventions. Review of the facility policy titled Fall Management dated 10/17/16 indicated each resident would be assessed throughout the course of treatment for different parameters such as: cognition, safety awareness, fall history, mobility, medications, or predisposing health conditions that could contribute to fall risk. An interdisciplinary plan of care would be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions. The interdisciplinary team would attempt to balance safety needs, resident rights, and quality of life issues that would positively impact each resident's individual situation and reduce the risk of occurrence. Residents who experienced a fall would receive prompt medical attention. Immediate needs would be quickly assessed and responded to. A plan would be identified and implemented as necessary to protect the resident and/or others from recurrence. This deficiency represents non-compliance investigated under Complaint Number OH00161220.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the American Nurses Association (ANA) guidelines for accuracy of documentation, the facility failed to ensure staff accurately documented the presence of interventions to prevent a fall. This affected one of three residents reviewed for falls (Resident #137). The facility census was 147. Findings include: Clinical record review revealed Resident #137 was admitted on [DATE] with diagnoses including diabetes mellitus, pulmonary disease, cerebral vascular disease, heart failure with a cardiac defibrillator implanted device, high blood pressure, atherosclerotic disease, peripheral vascular disease, cataracts with visual disturbances, thrombocytopenia, carpal tunnel syndrome of upper limbs, osteoarthritis, and breast cancer. Resident #137 had medical conditions including low back pain, unsteadiness on feet, muscle weakness, and abnormal gait, mobility and need for assistance with personal care. Review of Resident #137's plan of care initiated 12/05/2023 indicated a risk of falls related to acute/unstable medical condition, stroke, debilitation, weakness, disease process, impaired balance, pain, history of falls, poor coordination, unsteady gait, and visual deficit. Interventions on the plan of care included to keep the bed in the lowest position, Call, don't fall sign, Dycem (non skid mat) to wheelchair, encourage and remind to ask for assistance, encourage Resident #137 to wear non-skid socks at all times when not wearing shoes, encourage resident to ask for assistance to get items out of closet, encourage resident to not do activity of daily living tasks while sitting on rollator, ensure call light was within reach, ensure environment was free of clutter, have commonly used articles within easy reach, maintain a clear pathway, new shoes provided to resident, non-skid strips next to bed, provide rest periods and resident was to wear proper and non slip footwear. An observation of Resident #137's room on 01/27/28 at 2:00 P.M. and on 01/28/25 at 8:30 A.M. revealed there was no Dycem on Resident #137's wheelchair and there were no non-skid strips located on the floor beside Resident #137's bed. Review of Resident #137's treatment administration record (TAR) dated 01/01/25 to 01/27/25 indicated documentation the Dycem was present on Resident #137's wheelchair and the non-skid strips were present on the floor. During an interview on 01/28/25 at 9:15 A.M., Certified Nursing Assistant (CNA) #150 verified there was no Dycem on Resident #137's wheelchair and there were no non-skid strips located on the floor beside Resident #137's bed. An interview with Assistant Director of Nursing (ADON) #151 on 01/28/25 at 2:45 P.M. verified the documentation on Resident #137's TAR indicated the care planned interventions of Dycem to wheelchair and non-skid strips were in place from 01/01/25 to 01/27/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the American Nurses Association (ANA) guidelines for accuracy of documentation dated 2010 indicated clear, accurate, and accessible documentation was an essential element of safe, quality, evidence-based nursing practice. Accurate nursing documentation significantly influenced the quality of patient care. It not only provided a clear picture of the patient's medical history but also served as a vital tool of communication among healthcare professionals. When filled accurately and systematically, it could also protect nurses legally if there was a complaint or lawsuit related to patient care. This deficiency represents non-compliance investigated under Complaint Number OH00161120.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, policy and procedure review, and review of the Centers for Disease Control (CDC) guidance, the facility failed to ensure staff performed appropriate hand hygiene and ensure all staff implemented enhanced barrier precautions. This affected two of three residents reviewed for incontinence care (Residents #65 and #8) and one of 20 residents who ate their meals and resided on the 100 hall (Resident #58). These failures also had the potential to affect all 20 residents currently residing on the 100 hall (Residents #8 #17, #25, #37, #58, #65, #71, #74, #75, #78, #94, #95, #105, #109, #117, #135, #137, #139, #143 and #146). The facility census was 147. Findings include: 1. Clinical record review revealed Resident #65 was admitted on [DATE] with diagnoses including liver cancer, chronic bronchitis, aphasia, high blood pressure, heart failure, intermittent explosive disorder, dementia, anxiety, viral hepatitis, hyperlipidemia, ventral hernia, and intestinal obstruction. Review of Resident #65's plan of care initiated on 08/02/25 indicated Resident #65 was at risk for infection related to chronic disease including viral hepatitis with liver cell carcinoma. The goal of the plan of care was for Resident #65 to remain free from signs and symptoms of infection. Further review of Resident #65's care plan initiated on 08/02/25 indicated Resident #65 had an alteration in elimination with frequent bowel and bladder incontinence. Intervention on the plan of care included to provide incontinence care as needed. An observation of Certified Nursing Assistant (CNA) #150 and Assistant Director of Nursing (ADON) #151 on 01/28/25 at 11:00 A.M. perform Resident #65's incontinence care revealed a failure to perform hand hygiene to prevent cross contamination of germs. ADON #151 did not perform hand hygiene prior to assisting Resident #65 with incontinence care. ADON #151 donned a pair of gloves and removed the urine soaked bed linen by assisting Resident #65 with turning side-to-side. ADON #151 placed the soiled linens in a plastic bag and removed her gloves and did not perform hand hygiene. ADON #151 then donned another pair of gloves and proceeded to assist CNA #150 with obtaining clean linens needed for the incontinence care changing her gloves a third time during the process and donning another pair of gloves without performing hand hygiene. CNA #150 proceeded to don two pairs of gloves and cleaned Resident #65's perineal area with soap was water and cleaned the urine and feces from Resident #65's skin. CNA #150 completed cleaning Resident #65's perineal area of feces and urine and removed one of the two pairs of gloves and proceeded to assist Resident #65 with donning a clean incontinence brief. CNA #150 changed her gloves and did not perform hand hygiene. CNA #150 then obtained clothing from Resident #65's closet and assisted him with donning the clothing and transferring him to his wheelchair using a sit-to-stand mechanical lift. CNA #150 then removed the soiled linen from Resident #65's room, exited the room and placed the soiled linen in the shower room and did not wash her hands and proceeded to gather clean linens and placed the linens in Resident #65's room. An interview with CNA #150 on 01/28/25 at 11:30 A.M. verified the above findings and confirmed she should have performed hand hygiene between glove changes and before she obtained the clean linens from the shower room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with ADON #151 on 01/28/25 at 11:45 A.M. verified she had failed to perform hand hygiene between glove changes while assisting with Resident #65's incontinence care. 2. Clinical record review revealed Resident #8 was admitted on [DATE] and re-admitted on [DATE] with diagnoses including end stage prostate/colon/bone/skin cancer, diabetes mellitus, severe malnutrition, severe adjustment disorder with anxiety, anemia, bradycardia, venous thrombosis, and schwannomatosis (a rare genetic disorder characterized by the formation of multiple benign tumors called schwannomas on the nerve). Review of Resident #8's plan of care initiated on 01/14/25 indicated Resident #8 was at risk for infection related to cancer, chronic disease, implanted vascular access device to right chest, and pressure wound. The goal of the plan of care was for Resident #8 to remain free of signs and symptoms of infection. Interventions included to follow enhanced barrier precautions (EBP) as needed and to assess for signs and symptoms of infection and report to physician; redness, swelling, increased pain, purulent drainage, elevated temperature, change in color of secretions, cough, congestion, abnormal lung sounds, diarrhea, and/or vomiting. Further review of Resident #8's plan of care initiated on 01/14/25 indicated Resident #8 had a alteration in elimination with frequent episodes of bowel and bladder incontinence. Interventions on the plan of care indicated to monitor signs and symptoms of urinary tract infection including elevated temperature dysuria, flank pain, hematuria, and foul smelling urine and report to the physician and to provide incontinence care as needed. Review of Resident #8's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 had frequent bowel and bladder incontinence. An observation on 01/28/25 at 10:46 A.M. of CNA #150 checking Resident #8 for incontinence revealed CNA #150 failed to wear appropriate personal protective equipment (PPE) . CNA #150 entered Resident #8's room and donned a pair of gloves and proceeded to assist Resident #8 with rolling side-to-side. CNA #150 then opened Resident #8's incontinence brief to ensure the incontinence brief was dry. CNA #150 then secured the incontinence brief and assisted Resident #8 with repositioning for comfort. Outside of Resident #8's room a cart with three drawers containing PPE was present with a sign located above Resident #8's name plate outside of his room. The sign indicated enhanced barrier precautions (EBP) should be implemented when providing care for Resident #8. CNA #150 verified the signage was present outside of Resident #8's room and verified she had failed to wear the additional PPE including a gown. ADON #151 was present during the observation and also confirmed Resident #8 had EBP in place due to the presence of a wound and verified CNA #150 should have implemented the EBP when checking Resident #8 for incontinence. 3. Clinical record review revealed Resident #58 was admitted on [DATE] with diagnoses including anemia, high blood pressure, peripheral vascular disease, hyperlipidemia, arthritis, dementia, malnutrition, anxiety, depression, schizophrenia, and asthma. Review of Resident #58's MDS assessment dated [DATE] indicated Resident #58 needed assistance with meals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed Resident #8 was admitted on [DATE] and re-admitted on [DATE] with diagnoses including end stage prostate/colon/bone/skin cancer, diabetes mellitus, severe malnutrition, severe adjustment disorder with anxiety, anemia, bradycardia, venous thrombosis, and schwannomatosis (a rare genetic disorder characterized by the formation of multiple benign tumors called schwannomas on the nerves). Review of Resident #8's MDS assessment dated [DATE] indicated Resident #8 needed assistance with meals. An observation of the breakfast meal tray service on 01/28/25 at 8:12 A.M. revealed CNA #150 was delivering trays to the residents on the 100 hallway. CNA #150 opened the food cart and obtained a meal tray for Resident #8 and delivered the tray. CNA #150 assisted with repositioning Resident #8 in bed and setting-up the food items on the meal tray. Resident #8 refused his meal. CNA #150 exited Resident #8's room, did not perform hand hygiene and returned Resident #8's meal tray to the meal cart. CNA #150 proceeded to obtain Resident #58's meal tray and delivered the meal to Resident #58. CNA #150 assisted with the set-up of Resident #58's meal tray and exited the room and obtained a packet of honey, opened the packet and emptied the packet of honey on Resident #58's cereal. CNA #150 exited Resident #58's room and was stopped and asked to perform hand hygiene. Interview on 01/28/25 at 8:40 A.M. with CNA #150 verified the above observations and confirmed she did not perform hand hygiene between delivery of the meal trays between Resident #8 and Resident #58. CNA #150 stated she was not aware she was supposed to perform hand hygiene between delivery of the meal tray to each resident. Review of the facility policy titled Hand Hygiene revised 11/23/16 indicated hand hygiene would be properly performed to assist in the prevention of spreading infections. Staff would perform hand hygiene when indicated, using proper technique. Alcohol-based hand sanitizers were the most effective products for reducing the number of germs on the hands of healthcare providers. Alcohol-based hand sanitizers were the preferred method for cleaning hands in most clinical situations. During routine resident care, use of alcohol-based hand sanitizers was acceptable: a. Before touching a resident, b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, c. Before moving from work on a soiled body site to a clean body site on the same resident (when hands are not visibly dirty), d. After touching a resident or the resident's immediate environment, e. After contact with blood, body fluids or contaminated surfaces, f. Immediately after glove removal, g. When there was a single case of Clostridium difficile or Norovirus or during non-outbreak times in the facility, (continued on next page)

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	365134	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Ridge Nursing & Rehabilitation Center	721 Hickory St Akron, OH 44303

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. All other situations not listed under bullet seven (7.) of this policy. Hands were washed with soap and water: a. Whenever they were visibly dirty, b. Before eating, c. After using the restroom, d. After caring for a person with known or suspected infectious diarrhea, and, e. After caring for a resident with known or suspected Clostridium (C.) difficile or Norovirus infection during an outbreak, or if infection rates of C.difficile infection (CDI) are high. Review of the facility policy titled Infection Prevention and Control Program (IPCP) indicated it was a policy of the facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Item number three indicated: Hand Hygiene Protocol a. All staff shall perform hand hygiene their when coming on duty, between resident contacts, after handling contaminated objects, after PPE removal, before/after eating, before/after toileting, and before going off duty. b. Staff shall perform hand hygiene before and after performing resident care procedures and per our facility's established hand hygiene procedure. Review of the CDC enhanced barrier precautions information dated 10/20/24 indicated during high contact resident care task including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, during device care or use, and during wound care enhanced barrier precautions should be implemented. Enhanced barrier precautions included the use of a gown and gloves during high contact resident care tasks. Review of the census provided by the facility revealed Residents #8 #17, #25, #37, #58, #65, #71, #74, #75, #78, #94, #95, #105, #109, #117, #135, #137, #139, #143 and #146 resided on the 100 unit. This deficiency represents non-compliance investigated under Complaint Number OH00161669.