STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365814	A. BUILDING _____ B. WING _____	05/03/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORTLAND CENTER	369 N HIGH STREET CORTLAND, OH 44410

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of wound consult progress notes, and review of the National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury Stages resource, the facility failed to accurately assess three (Residents #35, #53, and #55) of three residents reviewed for pressure ulcer assessment. The facility census was 51 residents. Findings include: 1. Review of the closed medical record for Resident #55 revealed she was admitted to the facility 09/28/17 with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed she was cognitively intact with no behaviors. She was independent for eating and wheelchair locomotion. She was totally dependent for all other activities of daily living (ADL)'s. She had a supra pubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow) and a [MEDICAL CONDITION] (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). She had a stage four pressure ulcer present on admission. Review of the NPUAP Pressure Injury Stages resource defines a pressure ulcer as a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. Review of the NPUAP Pressure Injury Stages resource defines a stage four pressure ulcer as a full thickness tissue loss with exposed bone, tendon or muscle. Slough (yellow, tan, gray, green or brown) or eschar (tan, brown or black) may be present on some parts of the wound bed. Often include undermining and tunneling (undermining is less extensive, while tunneling penetrates more deeply into the tissue). Review of a weekly wound assessment, written by former Assistant Director of Nursing (ADON) #202, dated 11/21/17, revealed a new wound to the left thigh/left ischium, described as an abrasion, measuring 2.5 centimeters (cm) in length by 3.0 cm in width by 0.1 cm in depth. The wound bed was pink tissue. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the wound to the left thigh/left ischium measured 2.5 cm in length by 3.0 cm in width by 0.1 cm in depth. The wound bed now contained slough, and was described as unchanged. According to the NPUAP Pressure Injury Stages resource, the wound description should have been changed to reflect a stage three pressure ulcer, not an abrasion as described. This resource defines a stage three pressure ulcer as full thickness tissue loss; subcutaneous fat may be visible but bone, tendon or muscle are not exposed; slough may be present but does not obscure the depth of tissue loss; and may include undermining and tunneling. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the left thigh/left ischium now measured 2.5 cm in length by 3.0 cm in width and now had a depth of 0.4 cm. The wound bed still contained slough tissue. The wound was described as unchanged. The wound was still described as an abrasion. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the left thigh/left ischium now measured 2.5 cm in length by 3.0 cm in width and now had a depth of 0.6 cm. The wound bed still contained slough tissue. The wound was described as unchanged. The wound was still described as an abrasion. Review of the wound clinic consult note dated 02/08/18 revealed a wound to the sacrum, not previously identified by the facility. Review of a weekly wound assessment, written by former ADON #202, dated 02/13/18 revealed a new wound, described as moisture associated skin damage (MASD), to the sacrum/natal cleft measuring 0.4 cm in length by 0.4 cm in width, by 0.3 cm in depth. The assessment stated the wound was in-house acquired, identified on 02/09/18. This is the first documentation describing the wound, noted as being identified on 02/09/18. According to the NPUAP Pressure Injury Stages resource, this wound would be classified as a stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough). Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the left thigh/left ischium now measured 2.5 cm in length by 3.0 cm in width and now had a depth of 1.0 cm with 3.0 cm tunneling at o'clock. The wound bed still contained slough tissue. The wound was still described as an abrasion. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the wound to the sacrum/natal cleft measured 2.0 cm in length by 2.3 cm in width by 1.0 cm in depth. The wound base contained slough tissue and pink tissue. The wound was still being described as MASD. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the left thigh/left ischium now measured 2.5 cm in length by 3.0 cm in width and now had a depth of 1.0 cm with 5.0 cm tunneling at o'clock. The wound bed still contained slough tissue. The wound was still described as an abrasion. Review of the closed medical record revealed the resident was transferred to the hospital on [DATE] and admitted for a [DIAGNOSES REDACTED]. Interview on 05/01/18 at 4:30 P.M. with corporate Registered Nurse (RN) #201 verified that the wound to the sacrum/natal cleft was identified by the wound clinic on 02/08/18 and verified that the wound was a stage two pressure ulcer, not MASD. She verified that the first documented assessment of the wound to the sacrum/natal cleft by the facility was 02/13/18, five days after it was identified by the wound clinic. She also verified that the area to the left thigh/left ischium was a deteriorating pressure ulcer, not MASD as described by the facility. 2. Review of the medical record for Resident #35 revealed he was admitted to the facility 03/16/16 with [DIAGNOSES REDACTED]. Review of the significant change Minimum Data set 3.0 (MDS) assessment dated [DATE] revealed he required limited assistance with toileting and dressing, supervision with bed mobility and transfers, and was independent for all other activities of daily living (ADL)'s. He was continent of bowel and bladder. He had a stage three pressure ulcer to his right buttock which was present on admission. Cognition and behaviors were not assessed. Review of the quarterly assessment dated [DATE] revealed he was cognitively intact with no behaviors. He had a stage three pressure ulcer, present on admission. Review of a weekly wound note dated 03/27/18, written by former ADON #202, revealed the stage three pressure ulcer to the right buttock measured 5.5 cm in length by 4.0 cm in width by 0.1 cm in depth. Review of the weekly wound note dated 04/03/18, written by RN #203, revealed the stage three pressure ulcer to the right buttock measured 13 cm in length by 6.7 cm in width by 0.2 cm in depth. The wound was described as unchanged. Interview on 04/30/18 at 10:30 A.M. with Resident #35 revealed the wound on his right buttock did not deteriorate from 03/27/18 when the former ADON #202, no longer employed at the facility, measured it to 04/03/18 when RN #203 measured it. He stated that ADON #202 must have measured it incorrectly. Interview on 05/01/18 at 12:30 P.M. with corporate RN #201 verified the significant discrepancy in the wound measurements

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) from 03/27/18 to 04/03/18. 3. Resident #53 was admitted [DATE] with [DIAGNOSES REDACTED]. Review of an incident accident log from 10/01/17 through discharge 04/16/18, revealed Resident #53 fell on [DATE], 10/29/17, 12/05/17, 02/09/18, and 04/07/18. Review of the Fall Investigation Summaries from admission through discharge revealed the same, Resident #53 fell on [DATE], 10/29/17, 12/05/17, 02/09/18, and 04/07/18. However, review of a nurse's note dated 04/06/18 at 8:44 A.M. revealed documentation which read; This note is a follow-up to a fall. Review of the same nurses note revealed Resident #53 was assessed post fall with vital signs, mobility, neurological status, pain, assistance required for activities of daily living, and continence status. An interview was completed with Licensed Practical Nurse (LPN) #110 on 04/30/18 at 12:21 P.M. LPN #110 verified she had written the nurses note. LPN #110 verified Resident #53 had not fallen from 12/05/17 until 04/07/18. LPN #110 revealed the documentation should have referenced the resident's wound. LPN #110 explained she must have pushed the wrong tab on the resident's computerized charting. This deficiency substantiates Complaint Number OH 430.
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** Based on interview and record review, the facility failed to ensure a knee brace was provided to address pain and immobility as ordered by the physician. This affected one (Resident #53) of three residents reviewed for falls. Findings include: Resident #53 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Fall Risk Assessments dated 10/09/17, 10/19/17, 10/26/17, 10/29/17, 12/05/17, 02/09/18, and 04/07/18 revealed resident #53 was at a high risk for falls. Review of an incident accident log from 10/01/17 through discharge 04/16/18, revealed Resident #53 fell on [DATE], 10/29/17, 12/05/17, 02/09/18, and 04/07/18. Following the fall on 04/07/18, nurses notes revealed Resident #53 complained of left knee pain and reduced mobility. The physician ordered an x-ray of the left knee. Review of the x-ray dated 04/08/18 revealed the left knee joint was intact with no fracture, dislocation or effusion seen. The x-ray concluded normal left knee. Resident #53 continued to complain of pain and the resident's primary physician ordered an orthopedic consult. Review of an orthopedic consult dated 04/10/18 revealed Resident #53 had acute pain of the left knee as a result of a sprained ligament. The treatment plan included rest, compression, application of ice, physical therapy, and a hinged brace to the left knee. Review of a Rehabilitation Progress Note dated 04/12/18 revealed Physical Therapist (PT) #111 met with Resident #53 to discuss the process to obtain the hinged knee brace. It was at this time, PT #111 was made aware of the resident's pending discharge to another nursing home. PT #111 explained it made more sense for Resident #53 to pursue the brace with that facility. The same note indicated the resident shook her head in agreement. Thus, no pursuit of the brace was done at that time. Review of the Medication Administration Record [REDACTED]. The Pain Flow Sheet assessed the intensity of pain on a scale of 1 to 10, with 10 as the greatest intensity. Resident #53 was receiving [MEDICATION NAME] 50 milligrams (mg.) every six hours, as needed for pain. [MEDICATION NAME] is an opioid pain medication. From 04/01/18 at 4:00 A.M., through 04/07/18 at 7:30 P.M., Resident #53 received 13 doses of [MEDICATION NAME]. The Pain Flow Sheet revealed the pain was aching, frequent, back pain that ranged between 6 and 8 on the pain scale. The pain was aggravated by movement. From 04/08/18 at 8:30 P.M. (following the fall) through discharge 04/16/18, Resident #53 received 22 doses of [MEDICATION NAME]. The Pain Flow Sheet revealed the pain was aching, frequent, back and left knee pain that ranged between 6 and 8 on the pain scale. The pain was aggravated by movement. An interview was completed with PT #111 on 05/01/18 at 9:11 A.M. PT #111 verified he was aware Resident #53 had fallen on 04/07/18. PT #111 revealed he assessed Resident #53 on 04/08/18. At the time of the assessment, PT #111 was notified Resident #53 had an appointment with the orthopedic physician. Therefore, PT #111 decided to defer the plan of care until Resident #53 was seen by the orthopedic physician. PT #111 revealed Resident #53 came to the therapy department on 04/12/18 and asked about the left knee brace. At the same time, he became aware she was transferring to another nursing home and would be transferred within the next 24 to 48 hours. PT #111 explained obtaining a knee brace was an extended process. It required a telephone call to the orthotist and approval from the insurance company. Then, it was usually another week before the orthopedic brace was made. Historically, PT #111 had had instances where a resident was transferred and the receiving facility dropped the ball. PT #111 believed it would be a [MEDICATION NAME] process if it was initiated by the receiving facility. PT #111 was aware Resident #53 was not transferred for six days following the physician order [REDACTED].#111 revealed the determination was made based on a 24 to 48 hour discharge. This deficiency substantiates Complaint Number OH 506 and Complaint Number OH 467.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of wound clinic notes, and review of the National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury Stages resource, the facility failed to timely follow a physician's orders [REDACTED].#55) of thee residents reviewed for pressure ulcers. Harm occurred when Resident #55 did not receive the physician ordered wound care consult (ordered on [DATE]) until 02/08/18. During the 14-week delay for the physician ordered wound consult, for an infected stage four pressure ulcer to the right ischium, the resident acquired an additional in-house pressure ulcer which progressively deteriorated, and not identified until she was assessed at the wound care clinic on 02/08/18. The facility census was 51 residents. Findings include: Review of the closed medical record for Resident #55 revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed she was cognitively intact with no behaviors. She was independent for eating and wheelchair locomotion. She was totally dependent for all other activities of daily living (ADL)'s. She had a supra pubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow) and a [MEDICAL CONDITION] (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). She had a stage four pressure ulcer present on admission. Review of the NPUAP Pressure Injury Stages resource defines a pressure ulcer as a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. Review of the NPUAP Pressure Injury Stages resource defines a stage four pressure ulcer as a full thickness tissue loss with exposed bone, tendon or muscle. Slough (yellow, tan, gray, green or brown) or eschar (tan, brown or black) may be present on some parts of the wound bed. Often include undermining and tunneling (undermining is less extensive, while tunneling penetrates more deeply into the tissue). Review of the closed medical record revealed the resident was having her wound to the right ischium assessed weekly by a in-house wound care consultant through 10/24/17. Review of the physician order [REDACTED]. Review of the medical record revealed the resident did not receive the wound care consult as ordered by the physician, until 02/08/18. Review of a weekly wound assessment, written by former Assistant Director of Nursing (ADON) #202, dated 11/21/17, revealed a new wound to the left thigh/left ischium, described as an abrasion, measuring 2.5 centimeters (cm) in length by 3.0 cm in width by 0.1 cm in depth. The wound bed was pink tissue. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the wound to the left thigh/left

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) ischium measured 2.5 cm in length by 3.0 cm in width by 0.1 cm in depth. The wound bed now contained slough, and was described as unchanged. According to the NPUAP Pressure Injury Stages resource, the wound description should have been changed to reflect a stage three pressure ulcer, not an abrasion as described. This resource defines a stage three pressure ulcer as Full thickness tissue loss; subcutaneous fat may be visible but bone, tendon or muscle are not exposed; slough may be present but does not obscure the depth of tissue loss; may include undermining and tunneling. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the left thigh/left ischium now measured 2.5 cm in length by 3.0 cm in width and now had a depth of 0.4 cm. The wound bed still contained slough tissue. The wound was described as unchanged. The wound was still described as an abrasion. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the left thigh/left ischium now measured 2.5 cm in length by 3.0 cm in width and now had a depth of 0.6 cm. The wound bed still contained slough tissue. The wound was described as unchanged. The wound is still described as an abrasion. Review of a physician's orders [REDACTED]. Review of the wound clinic consult note dated 02/08/18, revealed this was the resident's first visit to the wound care clinic. There was a wound to the sacrum, not previously identified by the facility, and wounds to the left and right ischiums. Review of a weekly wound assessment, written by former ADON #202, dated 02/13/18, revealed a new wound, described as moisture associated skin damage (MASD), to the sacrum/natal cleft measuring 0.4 cm in length by 0.4 cm in width, by 0.3 cm in depth. The assessment stated the wound was in-house acquired, identified on 02/09/18. This is the first documentation describing the wound, noted as being identified on 02/09/18. According to the NPUAP Pressure Injury Stages resource, this wound would be classified as a stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough). Review of a progress note dated 02/22/18 revealed the resident's wound care consultation appointment was cancelled due to facility transportation issues. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the left thigh/left ischium now measured 2.5 cm in length by 3.0 cm in width and now had a depth of 1.0 cm with 3.0 cm tunneling at 12 o'clock. The wound bed still contained slough tissue. The wound was still described as an abrasion. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the wound to the sacrum/natal cleft measured 2.0 cm in length by 2.3 cm in width by 1.0 cm in depth. The wound base contained slough tissue and pink tissue. The wound was still being described as MASD. Review of the weekly wound assessment dated [DATE], written by former ADON #202, revealed the left thigh/left ischium now measured 2.5 cm in length by 3.0 cm in width and now had a depth of 1.0 cm with 5.0 cm tunneling at 12 o'clock. The wound bed still contained slough tissue. The wound was still described as an abrasion. Review of the closed medical record revealed the resident was transferred to the hospital on [DATE] and admitted for a [DIAGNOSES REDACTED]. Interview on 05/01/18 at 4:30 P.M. with corporate Registered Nurse (RN) #201 verified that the wound to the sacrum/natal cleft was identified by the wound clinic on 02/08/18 and verified that the wound was a stage two pressure ulcer, not MASD. She verified that the first documented assessment of the wound to the sacrum/natal cleft by the facility was 02/13/18, five days after it was identified by the wound clinic. She also verified that the area to the left thigh/left ischium was a deteriorating pressure ulcer, not MASD as described by the facility. She stated the original wound care consultant the resident had from admission through 10/24/17 had quit, and the facility was unable to get another wound care consultant to see the resident in-house. She verified it was not until 01/23/18 the facility obtained an order to send the resident out to a wound care clinic, despite having an order for [REDACTED]. She also verified the facility cancelled a scheduled wound care consult on 02/22/18 due to facility transportation issues. This deficiency substantiates Complaint Number OH 506, Complaint Number OH 467, and Complaint Number OH 430.
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 interview and record review, the facility failed to ensure adequate assistance to prevent a fall; and failed to ensure a comprehensive and accurate falls investigation was completed. This affected one (Resident #53) of three residents reviewed for falls. Findings include: Resident #53 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set assessments dated 11/07/17, 12/30/17, and 02/01/18 revealed Resident #53 was non-ambulatory and required extensive assistance from two staff for bed mobility and transfers. Review of the Certified Nurse Aide-Activities of Daily Living (CNA-ADL) Tracking Form from 01/01/18 through discharge 04/16/18, revealed Resident #53 did not walk in her room or corridors. Review of Fall Risk Assessments dated 10/09/17, 10/19/17, 10/26/17, 10/29/17, 12/05/17, and 02/09/18 revealed Resident #53 was at a high risk for falls. Review of an incident accident log from 10/01/17 through 02/09/18 revealed Resident #53 fell four times since admission. The falls occurred on 10/12/17, 10/29/17, 12/05/17, and 02/09/18. Review of three of four falls, dated 10/12/17, 10/29/17 and 12/05/17, revealed no concerns. However, review of an Incident Report-Investigation Summary dated 02/09/18 revealed an unidentified state tested nurse aide (STNA) witnessed resident lower herself to floor in bathroom. Further review revealed on 02/08/18 (one day prior to the fall), Resident #53 was referred to physical therapy (PT) due to a new onset of decreased strength, decreased functional mobility, decreased neuromotor control, decreased coordination, increased need for assistance from others, reduced balance, reduced activity of daily living participation, and compromised physical exertion level during activity. Review of the Investigative Summary nursing description note at the time of the fall, dated 02/09/18 at 6:50 A.M., revealed an STNA alerted the nurse that Resident #53 had fallen while walking to the bathroom. The nurse found Resident #53 sitting on her buttocks. The resident's wheelchair was behind her and the walker was in front of her. The same note quoted Resident #53 stating, I had walked to the bathroom twice yesterday with therapy and I thought I could handle it this morning but my knees had other plans. My legs gave out, I went down easy. Nothing hurts. Continued review revealed a witness statement dated 02/09/18 stating: (Resident #53) asked the new aide to follow her to the bathroom as she walked with walker. (Resident #53) fell . The statement was signed by STNA #112. An interview was completed with STNA #112 on 05/01/18 at 12:22 P.M. STNA #112 revealed she was asked to write the witness statement because the new aide came to her and told her what happened. STNA #112 revealed she did not know the name of the aide because she had not seen her before the day of the incident, and had not seen her since the incident. STNA #112 did not know if the aide had been employed by the facility or a nursing agency. STNA #112 revealed the unidentified nurse aide told her Resident #53 wanted to walk to the bathroom. The aide helped Resident #53 out of bed and stood behind her while Resident #53 tried to walk to the bathroom and then, fell . STNA #112 revealed she provided care and services for Resident #53 from (MONTH) (YEAR) to (MONTH) (YEAR). STNA #112 revealed Resident #53 did not walk with the nursing staff and walked only with therapy. STNA #112 described toileting Resident #53. STNA #112 explained Resident #53 could put her legs over the side of the bed onto the floor and used her walker to balance. Then, Resident #53 was able to turn, pivot and sit in her wheelchair. The nursing staff would wheel her into the bathroom and Resident #53 used the walker to stand and pivot onto the toilet. Review of the same Incident Report-Investigative Summary dated 02/09/18, revealed a revision dated 02/16/18, written by the former Director of Nursing (DON) #113. The revision indicated the following: On 02/09/18 at approximately 6:50 A.M., STNA was walking resident to the bathroom. Resident stated her legs became weak and gave-out. STNA lowered resident to the floor. This deficiency substantiates Complaint Number OH 614, Complaint Number OH 506, and Complaint Number OH 467.