| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365826 | A. Building<br>B. Wing | 01/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Continuing Healthcare of Cuyahoga Falls | 300 East Bath Road<br>Cuyahoga Falls, OH 44223 |

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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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015<br><br>Based on observation, interview, and record review, the facility failed to ensure Resident #75 diabetic foot ulcer treatments were completed as ordered. This affected one resident (Resident #75) out of two residents observed for wound care.<br><br>Findings include:<br><br>Review of Resident #75 medical record revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, dementia, hypertensive heart disease, and dysphasia.<br><br>Review of Resident #75's skin grid dated 01/05/22 reveled the resident has a diabetic ulcer on her left heel.<br><br>Review of Resident #75 January 2022 physician orders revealed an order dated 12/08/21, to cleanse area to left heel with normal saline solution, pat dry, apply oil emulsion gauze and a abdominal pad, and wrap with kerlix. The order was scheduled to be done every night.<br><br>Observation on 01/05/22 at 6:07 A.M. of Licensed Practical Nurse (LPN) #122 completing wound care on Resident #75 revealed LPN #122 removed the residents left heel dressing. The dressing was dated 01/03/21 and had LPN #116's initials.<br><br>Interview on 01/05/22 at 6:10 A.M. LPN #122 confirmed that Resident #75 did not receive as ordered wound care to her left heel on 01/04/21.<br><br>Review of the facility provided staffing schedule revealed that LPN #116 last worked the night of 01/02/22 to the morning of 01/03/22. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015<br><br>Based on observation, interview, and record review, the facility failed to ensure pressure ulcer interventions were in place, wound assessments were accurate, and treatments were completed as ordered for Resident #19, Resident #25, and Resident #57. Harm occurred when preventive pressure ulcer interventions were not in place for Resident #25, and the resident developed an unstageable pressure ulcer to the left lateral foot. This affected three residents (Resident #19, Resident #25, Resident #57) out of three residents reviewed for pressure ulcers.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #19 revealed an admitted [DATE]. Medical diagnoses included acute respiratory failure with hypoxia, diabetes insipidus, traumatic subdural hemorrhage with loss of consciousness. Resident #19 did not have any pressure areas upon admission to the facility.<br><br>Review of Resident #19 physician orders revealed an order, dated 10/06/21, to pad and protect bilateral heels every shift. An order dated 11/08/21 revealed the turn and reposition the resident every two hours for skin care.<br><br>Review of Resident #19's admission Braden Risk Assessment, dated 10/20/21, revealed he was at high risk for the development of pressure ulcers.<br><br>Review of the Resident #19's pressure skin grid, dated 11/03/21, revealed he had developed a pressure ulcer on his left ear. The wound measured 0.3 centimeters (cm) length by 0.2 cm in width. The area was superficial with red viable tissue. The area was not staged. The ear wound healed 11/10/21.<br><br>Review of Resident #19's Pressure skin grid, dated 11/17/21, revealed the resident had a healed pressure ulcer to his left buttocks. Continued review of the facility pressure skin grids revealed that the facility did not document when the pressure ulcer started or completed staging on the area.<br><br>Review of Resident #19's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively impaired and needed extensive assistance with two plus physical assist for bed mobility.<br><br>Review of Resident #19's Treatment Administration Record (TAR) revealed the resident's order to pad and protect bilateral heels every shift was not done on 11/04/21, 11/17/21, 11/19/21, 11/22/21, 12/01/21, 12/02/21, 12/09/21, 12/10/21, 21/11/21, 12/15/21, 12/16/21, 12/17/21, and 12/27/21. The TAR revealed the resident was not turned and repositioned every two hours on 11/17/21, 11/19/21, 11/22/21, 12/01/21, 12/02/21, 12/09/21, 12/10/21, 12/11/21, 12/1521, 12/16/21, 12/17/21, and 12/27/21.<br><br>Review of Resident #19's Pressure Skin Grid, dated 12/29/21, revealed Resident #19 had developed an unstageable pressure ulcer to the residents left lateral foot. The area measured 2 cm by 1 cm. The area had dark tissue and appeared as a closed scab.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #19's physicians orders revealed an order on 12/29/21 to apply skin prep to the residents left lateral plantar foot, place an abdominal pad, and wrap with kerlix daily on night shift.<br><br>Review of Resident #19 January 2022 TAR revealed Resident #19's left lateral foot treatment was not completed on 01/03/22.<br><br>Interview on 01/10/21 at 10:00 A.M. with Licensed Practical Nurse (LPN) #42 revealed she was the facility wound nurse. She confirmed she was not made aware of Resident #19's pressure ulcer on his buttocks until it was already healed. She also confirmed there was not documentation the wound was ever staged or evidence of when it first developed. She also confirmed pressure ulcer treatments and turning and repositioning as ordered were not in place for Resident #19 consistently as ordered.<br><br>Interview on 01/05/22 at 5:35 A.M. with LPN #115 revealed staffing on night shift could be better. She revealed wound treatments are missed due to low staffing and not having time to get them done. She continued when they are understaffed on night shift, residents are not able to be turned and repositioned every two hours, and timely incontinence care is not provided. LPN #115 worked throughout the entire facility.<br><br>Interview on 01/05/22 at 6:34 A.M. with LPN #136 revealed staffing in the facility was terrible. LPN #136 revealed at times all the assigned nursing tasks were not completed due to low staffing. LPN #136 also revealed residents are not always turned and repositioned every two hours. LPN #126 worked throughout the entire facility.<br><br>2. Review of Resident #25 medical record revealed an admitted [DATE]. Diagnoses included neuromuscular dysfunction of bladder, spinal stenosis, diabetes mellitus with diabetic neuropathy, and heart failure.<br><br>Review of Resident #25's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident required total assistance of one person for bed mobility and total assistance of one person physical assistance for transfers. Resident #25 was admitted with two stage four pressure areas. One to the the Left ischium and one to the sacrum.<br><br>Review of Resident #25's physician order dated 12/22/21 revealed a treatment to the residents left ischium to soak a kerlix in Dakins, use a piece of the Dakins kerlix to cleanse the wound bed, lightly pack with the wound with alginate and silver, and cover with a dry dressing, twice a day and as needed. An order dated 12/22/21 revealed a treatment for the resident's sacrum to soak a kerlix in Dakin's, use a piece of the Dakin's kerlix to clean the wound bed, lightly pack the wound with alginate with silver, then fill the rest of the wound with Dakin's kerlix peri-wound bed, and cover with a dry sterile dressing twice a day.<br><br>Review of Resident #25's care plan, dated 12/30/21, revealed the resident was at risk for impaired skin integrity related to lack of mobility. Interventions included resident educated on the need to limit time up in wheelchair, to change her position in bed every two hours and for comfort, complete treatments per order, and utilize pressure reduction devices if ordered.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the December 2021 Treatment Administration Record (TAR) revealed Resident #25 treatment to her left ischium was not completed twice a day on 12/24/21, 12/26/21, 12/27/21, and 12/29/21. Resident #25's sacrum treatment was not completed twice a day on 12/24/21, 12/26/21, 12/27/21, and 12/29/21.<br><br>Interview on 01/05/22 at 8:10 A.M. with Resident #25 revealed she does not get turned every two hours and she sometimes lays all day in the same position. She continued her treatments get pushed to different shifts or do not get done at all. She believed this was due to low staffing in the facility.<br><br>Interview on 01/05/22 at 1:56 PM with Administrator confirmed the facility does not have evidence Resident #25's pressure ulcer treatments were completed as ordered for the month of December 2021.<br><br>3. Review of Resident #57's medical record revealed an admitted [DATE]. Diagnoses included pressure induced deep tissue damage of the sacral region, diabetes mellitus, and dysphasia.<br><br>Review of Resident #57's physician orders revealed an order dated 11/30/21 to float the resident's bilateral heels while in bed. An order dated 12/01/21 revealed a treatment to cleanse sacral wound with normal saline, pat dry, skin prep peri wound, fill wound with Dakins moistened gauze and cover with foam dressing, twice daily until resolved. On 12/22/21 the sacral wound order changed to cleanse sacral wound with normal saline, pat dry, skin prep to peri-wound, cover wound bed with Santyl then fill wound with Dakin's moistened gauze, and cover with foam dressing twice daily.<br><br>Review of Resident #57's December 2021 and January 2022 TAR revealed the resident's sacral wound treatment was not completed as ordered on 12/02/21, 12/05/21, 12/06/21, 12/07/21, 12/09/21, 12/10/21, 12/11/21, 12/13/21, 12/14/21, 12/15/21, 12/16/21, 12/17/21, 12/20/21, 12/25/21, 12/27/21, 12/30/21, 01/02/22, 01/03/22, and 01/04/22.<br><br>Observation on 01/10/22 at 9:36 A.M. revealed Resident #57 to be lying on her back, her head of bed was slightly raised, and her heels were directly on the bed.<br><br>Interview on 01/10/22 at 9:36 A.M. with LPN #42 confirmed Resident #57 had an order to float her bilateral heels while she was in bed, and they were not floated as ordered. LPN #42 then placed a pillow under Resident #57's heels.<br><br>Interview on 01/05/22 at 5:35 A.M. with LPN #115 revealed staffing on night shift could be better. She revealed wound treatments are missed due to low staffing and not having time to get them done. She continued when they are understaffed on night shift, residents are not able to be turned and repositioned every two hours, and timely incontinence care is not provided. LPN #115 worked throughout the entire facility.<br><br>Interview on 01/05/22 at 6:34 A.M. with LPN #136 revealed staffing in the facility was terrible. LPN #136 revealed at times all the assigned nursing tasks were not completed due to low staffing. LPN #136 also revealed residents are not always turned and repositioned every two hours. LPN #126 worked throughout the entire facility.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 01/05/22 at 1:56 P.M. with Administrator confirmed that the facility does not have evidence that Resident #57's pressure ulcer treatments were completed as ordered for the month of December and January.<br><br>Review of undated facility policy titled Pressure Ulcer Prevention and Risk Identification revealed If a new skin area is identified a licensed nurse will initiate a skin grid/measurement flow record. The skin grid will be updated every seven days until resolved.<br><br>This deficiency substantiates Complaint Numbers OH00128640 and OH00128544. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015<br><br>Based on interview, observation, and record review, the facility failed to ensure Resident #25's splint devices were in place as ordered. This affected one resident (Resident #25) of three reviewed for orthopedic devices.<br><br>Findings include:<br><br>Review of Resident #25's medical record revealed an admitted [DATE]. Diagnoses included neuromuscular dysfunction of bladder, spinal stenosis, diabetes mellitus with diabetic neuropathy, and heart failure.<br><br>Review of Resident #25's care plan, dated 07/21/21, revealed the resident wore splint or brace orthotic related to contracture. Interventions included for the resident to wear bilateral splints while up in chair per tolerance up to eight hours a day.<br><br>Review of Resident #25's physicians orders revealed an order dated 07/22/21 for Resident #25 to wear bilateral lower extremity dynasplints while up in wheelchair as tolerated up to eight hours.<br><br>Review of Resident #25's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident required total assistance of one person for bed mobility and total assistance of one person physical assistance for transfers.<br><br>Review of the December 2021 Treatment Administration Record (TAR) revealed Resident #25's bilateral lower extremity dynasplints were not placed on the resident on 12/01/21, 12/02/21, 12/09/21, 12/10/21, 12/15/21, 12/17/21.<br><br>Interview on 01/05/22 at 8:10 A.M. with Resident #25 revealed she had leg splints, but the facility has not put them on in a long time. She believed this was due to low staffing in the facility.<br><br>Observations on 01/05/22 at 10:32 A.M. and 1:39 P.M. revealed Resident #25 was in her wheelchair. She did not have her bilateral lower extremity dynasplints in place.<br><br>Interview on 01/05/22 at 1:42 P.M. with Registered Nurse (RN) #105 revealed she did not believe Resident #25 wore splints. RN #105 looked at the resident's record and confirmed the resident was ordered bilateral lower extremity dynasplints while in her wheelchair. RN #105 then went into Resident #25's room and found the dynasplints in the residents closet. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015<br><br>Based on interview, record review, and policy review, the facility failed to ensure Resident #19 received monthly weights as ordered. This affected one resident (Resident #19) out of three residents reviewed for management of gastrostomy tubes.<br><br>Findings include:<br><br>Review of the medical record for Resident #19 revealed an admitted [DATE]. Medical diagnoses included acute respiratory failure with hypoxia, diabetes insipidus, traumatic subdural hemorrhage with loss of consciousness. Resident #19 received a new gastrostomy tube while in the hospital in 09/2021.<br><br>Review of Resident #19's physician order dated 10/07/21, revealed Resident #19 should be weighed monthly.<br><br>Review of Resident #19's quarterly Minimum Data Set (MDS) assessment, dated 12/16/21, revealed the resident had impaired cognition and needed extensive assistance with two plus physical assist for bed mobility.<br><br>Review of Resident #19's physicians orders revealed an order dated 11/08/21 for the resident to receive Isosource 1.5 (type of nutrition received gastrostomy tube) at 55 milliliters (ml) a hour continuously with 250 ml of water every four hours.<br><br>Review of Resident #19's weight record revealed a 11/05/21 weight of 181.2 pounds and a 01/08/22 weight of 170.1 pounds. The resident's medical record did not have a weight for December 2021.<br><br>Review of Resident #19's Treatment Administration Record (TAR) revealed the facility did not obtain a December 2021 weight.<br><br>Review of Resident #19's nutrition note, dated 01/10/22, revealed Resident #19 continued to receive nothing by mouth and received 100 percent of his nutrition via peg tube. The note indicated Resident #19's history of weights revealed on 01/08/22 the resident weighed 170 pounds, and his weight on 11/05/21 was 181 pounds. A noted weight loss trend of 7.36% in three months was identified.<br><br>Interview on 01/10/22 at 1:11 P.M. with Dietitian #44 revealed she has had issues with the facility obtaining weights as ordered.<br><br>Interview on 01/10/22 at 1:20 P.M. with Administrator confirmed Resident #19's December 2021 weight was not obtained as ordered.<br><br>Review of the facility's undated policy titled, Weight Policy and Procedure, revealed weights would be obtained at least monthly in order to identify those residents who may be at nutritional risk and require further evaluation and monitoring.<br><br>This deficiency substantiates Complaint Number OH00128544. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015<br><br>Based on interview, record review, and policy review, the facility failed to ensure Resident #19's tracheostomy care was provided as ordered. This affected one resident (Resident #19) out three residents reviewed for tracheostomy care.<br><br>Findings include:<br><br>Review of the medical record for Resident #19 revealed an admitted [DATE]. Medical diagnoses included acute respiratory failure with hypoxia, diabetes insipidus, traumatic subdural hemorrhage with loss of consciousness. The resident had a Tracheostomy.<br><br>Review of Resident #19's quarterly Minimum Data Set (MDS) assessment, dated 12/16/21, revealed the resident had impaired cognition.<br><br>Review of Resident #19's December 2021 physicians orders revealed orders for tracheostomy care every shift and as needed, change tracheostomy collar every three days and as needed, and suction as needed to clear secretions as needed.<br><br>Review of Resident #19's Treatment Administration Record revealed his tracheostomy care was not completed as ordered on 12/01/21, 12/02/21, 12/09/21, 12/10/21, 12/11/21, 12/15/21, 12/16/21, 12/17/21, and 12/27/21.<br><br>Interview on 01/10/22 at 1:20 P.M. with Administrator confirmed the lack of evidence Resident #19's tracheostomy care was not completed as ordered on 12/01/21, 12/02/21, 12/09/21, 12/10/21, 12/11/21, 12/15/21, 12/16/21, 12/17/21, and 12/27/21.<br><br>Review of the facility's undated policy titled, General Considerations for Tracheostomy Care, revealed tracheostomy care was performed every eight hours and as needed unless otherwise ordered. The focus of routine care was to keep the tube clean and free of secretions and encrustations in an effort to prevent infection and maintain a patient airway.<br><br>This deficiency substantiates Complaint Number OH00128544. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015<br><br>Based on observation, interview, record review, and facility assessment review, the facility failed to ensure sufficient staffing in the facility to meet the needs of all residents. This had the potential to affect all 75 residents residing in the facility.<br><br>Findings include:<br><br>1. Review of the staffing schedule for 12/28/21 revealed Licensed Practical Nurse (LPN) #122 worked by herself from 12:00 A.M. through 7:00 A.M.<br><br>Review of the facility census revealed that the facility had 74 residents in house 12/28/21.<br><br>Review of the Facility Assessment, dated 09/2021, revealed staffing should be based on resident population and acuity.<br><br>Interview on 01/11/22 at 2:57 P.M. with LPN #122 revealed she worked from 12:00 A.M. through 7:00 A.M. on 12/28/21 by herself. She stated she did not feel comfortable with taking care of that many residents and some with a higher acuity. She stated she was not able to complete all of her treatments and medications timely.<br><br>Interview on 01/10/22 at 1:20 P.M. with the Administrator confirmed LPN #122 was required to work by herself on 12/28/21 due to the unavailability of all other nurses.<br><br>2. Review of the medical record for the Resident #25 revealed an admitted [DATE]. Diagnoses included neuromuscular dysfunction of bladder, spinal stenosis, diabetes mellitus with diabetic neuropathy, and heart failure.<br><br>Interview on 01/05/22 at 8:10 A.M. with Resident #25 revealed she does not get turned every two hours and she sometimes lays all day in the same position. She continued her treatments get pushed to different shifts or do not get done at all. She also revealed that she has leg splints, but the facility has not put them on in a long time. She believed this was due to low staffing in the facility.<br><br>Review of Resident #25's physician's orders revealed an order dated 07/22/21 for Resident #25 to wear bilateral lower extremity dynasplints while up in wheelchair as tolerated up to eight hours. An order dated 12/22/21 revealed a treatment to the resident's left ischium to soak kerlix in Dakin's, use a piece of the Dakin's kerlix to cleanse the wound bed, lightly pack with the wound with alginate and silver, and cover with a dry dressing, twice a day as needed. An order dated 12/22/21 revealed a treatment to the resident's sacrum to soak a kerlix in Dakin's, use a piece of the Dakin's kerlix to clean the wound bed, lightly pack the wound with alginate with silver, then fill the rest of the wound with Dakin's kerlix, and cover with a dry sterile dressing twice a day.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the December 2021 Treatment Administration Record (TAR) revealed Resident #25's bilateral lower extremity dynasplints were not placed on the resident on 12/01/21, 12/02/21, 12/09/21, 12/10/21, 12/15/21, 12/17/21. Resident #25 treatment to her left ischium was not completed as ordered on 12/24/21, 12/26/21, 12/27/21, and 12/29/21. Resident #25's sacrum treatment was not completed as ordered on 12/24/21, 12/26/21, 12/27/21, and 12/29/21.<br><br>Interview on 01/05/22 at 8:10 A.M. with Resident #25 revealed she does not get turned every two hours and she sometimes lays all day in the same position. She continued her treatments get pushed to different shifts or do not get done at all. she had leg splints, but the facility has not put them on in a long time. She believed this was due to low staffing in the facility.<br><br>Observations on 01/05/22 at 10:32 A.M. and 1:39 P.M. revealed Resident #25 was in her wheelchair. She did not have her bilateral lower extremity dynasplints in place.<br><br>Interview on 01/05/22 at 1:42 P.M. with Registered Nurse (RN) #105 revealed she did not believe Resident #25 wore splints. RN #105 looked at the resident's record and confirmed the resident was ordered bilateral lower extremity dynasplints while in her wheelchair. RN #105 then went into Resident #25's room and found the dynasplints in the residents closet.<br><br>Interview on 01/05/22 at 1:56 PM with Administrator confirmed the facility does not have evidence Resident #25's pressure ulcer treatments were completed as ordered for the month of December 2021.<br><br>3. Review of Resident #57's medical record revealed an admitted [DATE]. Diagnoses included pressure induced deep tissue damage of the sacral region, diabetes mellitus, and dysphasia.<br><br>Review of Resident #57's physician orders revealed an order dated 11/30/21 to float the resident's bilateral heels while in bed. An order dated 12/01/21 revealed a treatment to cleanse sacral wound with normal saline, pat dry, skin prep peri wound, fill wound with Dakins moistened gauze and cover with foam dressing, twice daily until resolved. On 12/22/21 the sacral wound order changed to cleanse sacral wound with normal saline, pat dry, skin prep to peri-wound, cover wound bed with Santyl then fill wound with Dakin's moistened gauze, and cover with foam dressing twice daily.<br><br>Review of Resident #57's December 2021 and January 2022 TAR revealed the resident's sacral wound treatment was not completed as ordered on 12/02/21, 12/05/21, 12/06/21, 12/07/21, 12/09/21, 12/10/21, 12/11/21, 12/13/21, 12/14/21, 12/15/21, 12/16/21, 12/17/21, 12/20/21, 12/25/21, 12/27/21, 12/30/21, 01/02/22, 01/03/22, and 01/04/22.<br><br>Observation on 01/10/22 at 9:36 A.M. revealed Resident #57 to be lying on her back, her head of bed was slightly raised, and her heels were directly on the bed.<br><br>Interview on 01/10/22 at 9:36 A.M. with LPN #42 confirmed Resident #57 had an order to float her bilateral heels while she was in bed, and they were not floated as ordered. LPN #42 then placed a pillow under Resident #57's heels.<br><br>(continued on next page) |

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|---|---|---|---|
| | 365826 | A. Building<br>B. Wing | 01/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Continuing Healthcare of Cuyahoga Falls | 300 East Bath Road<br>Cuyahoga Falls, OH 44223 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 01/05/22 at 5:35 A.M. with LPN #115 revealed staffing on night shift could be better. She revealed wound treatments are missed due to low staffing and not having time to get them done. She continued when they are understaffed on night shift, residents are not able to be turned and repositioned every two hours, and timely incontinence care is not provided. LPN #115 worked throughout the entire facility.<br><br>Interview on 01/05/22 at 6:34 A.M. with LPN #136 revealed staffing in the facility was terrible. LPN #136 revealed at times all the assigned nursing tasks were not completed due to low staffing. LPN #136 also revealed residents are not always turned and repositioned every two hours. LPN #126 worked throughout the entire facility.<br><br>Interview on 01/05/22 at 1:56 P.M. the Administrator confirmed that the facility does not have evidence that Resident #57's pressure ulcer treatments were completed as ordered for the month of December and January.<br><br>4. Review of the medical record for Resident #19 revealed an admitted [DATE]. Medical diagnoses included acute respiratory failure with hypoxia, diabetes insipidus, traumatic subdural hemorrhage with loss of consciousness. Resident #19 did not have any pressure areas upon admission to the facility.<br><br>Review of Resident #19 physician orders revealed an order, dated 10/06/21, to pad and protect bilateral heels every shift. An order dated 11/08/21 revealed the turn and reposition the resident every two hours for skin care.<br><br>Review of Resident #19's admission Braden Risk Assessment, dated 10/20/21, revealed he was at high risk for the development of pressure ulcers.<br><br>Review of the Resident #19's pressure skin grid, dated 11/03/21, revealed he had developed a pressure ulcer on his left ear. The wound measured 0.3 centimeters (cm) length by 0.2 cm in width. The area was superficial with red viable tissue. The area was not staged. The ear wound healed 11/10/21.<br><br>Review of Resident #19's Pressure skin grid, dated 11/17/21, revealed the resident had a healed pressure ulcer to his left buttocks. Continued review of the facility pressure skin grids revealed that the facility did not document when the pressure ulcer started or completed staging on the area.<br><br>Review of Resident #19's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively impaired and needed extensive assistance with two plus physical assist for bed mobility.<br><br>Review of Resident #19's Treatment Administration Record (TAR) revealed the resident's order to pad and protect bilateral heels every shift was not done on 11/04/21, 11/17/21, 11/19/21, 11/22/21, 12/01/21, 12/02/21, 12/09/21, 12/10/21, 21/11/21, 12/15/21, 12/16/21, 12/17/21, and 12/27/21. The TAR revealed the resident was not turned and repositioned every two hours on 11/17/21, 11/19/21, 11/22/21, 12/01/21, 12/02/21, 12/09/21, 12/10/21, 12/11/21, 12/1521, 12/16/21, 12/17/21, and 12/27/21.<br><br>Review of Resident #19's Pressure Skin Grid, dated 12/29/21, revealed Resident #19 had developed an unstageable pressure ulcer to the residents left lateral foot. The area measured 2 cm by 1 cm. The area had dark tissue and appeared as a closed scab.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of Resident #19's physicians orders revealed an order on 12/29/21 to apply skin prep to the residents left lateral plantar foot, place an abdominal pad, and wrap with kerlix daily on night shift.<br><br>Review of Resident #19 January 2022 TAR revealed Resident #19's left lateral foot treatment was not completed on 01/03/22.<br><br>Interview on 01/10/21 at 10:00 A.M. with Licensed Practical Nurse (LPN) #42 revealed she was the facility wound nurse. She confirmed she was not made aware of Resident #19's pressure ulcer on his buttocks until it was already healed. She also confirmed there was not documentation the wound was ever staged or evidence of when it first developed. She also confirmed pressure ulcer treatments and turning and repositioning as ordered were not in place for Resident #19 consistently as ordered.<br><br>Interview on 01/05/22 at 5:35 A.M. with LPN #115 revealed staffing on night shift could be better. She revealed wound treatments are missed due to low staffing and not having time to get them done. She continued when they are understaffed on night shift, residents are not able to be turned and repositioned every two hours, and timely incontinence care is not provided. LPN #115 worked throughout the entire facility.<br><br>Interview on 01/05/22 at 6:34 A.M. with LPN #136 revealed staffing in the facility was terrible. LPN #136 revealed at times all the assigned nursing tasks were not completed due to low staffing. LPN #136 also revealed residents are not always turned and repositioned every two hours. LPN #126 worked throughout the entire facility.<br><br>5. Review of the medical record for Resident #19 revealed an admitted [DATE]. Medical diagnoses included acute respiratory failure with hypoxia, diabetes insipidus, traumatic subdural hemorrhage with loss of consciousness. Resident #19 received a new gastrostomy tube while in the hospital in 09/2021.<br><br>Review of Resident #19's physician order dated 10/07/21, revealed Resident #19 should be weighed monthly.<br><br>Review of Resident #19's quarterly Minimum Data Set (MDS) assessment, dated 12/16/21, revealed the resident had impaired cognition and needed extensive assistance with two plus physical assist for bed mobility.<br><br>Review of Resident #19's physicians orders revealed an order dated 11/08/21 for the resident to receive Isosource 1.5 (type of nutrition received gastrostomy tube) at 55 milliliters (ml) a hour continuously with 250 ml of water every four hours.<br><br>Review of Resident #19's weight record revealed a 11/05/21 weight of 181.2 pounds and a 01/08/22 weight of 170.1 pounds. The resident's medical record did not have a weight for December 2021.<br><br>Review of Resident #19's Treatment Administration Record (TAR) revealed the facility did not obtain a December 2021 weight.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of Resident #19's nutrition note, dated 01/10/22, revealed Resident #19 continued to receive nothing by mouth and received 100 percent of his nutrition via peg tube. The note indicated Resident #19's history of weights revealed on 01/08/22 the resident weighed 170 pounds, and his weight on 11/05/21 was 181 pounds. A noted weight loss trend of 7.36% in three months was identified.<br><br>Interviews with on 01/05/22 at 5:33 A.M. and 5:53 A.M. with LPN #115 and STNA #126 revealed weights were not always able to be obtained as ordered due to insufficient staffing.<br><br>Interview on 01/10/22 at 1:11 P.M. with Dietitian #44 revealed she has had issues with the facility obtaining weights as ordered.<br><br>Interview on 01/10/22 at 1:20 P.M. with Administrator confirmed Resident #19's December 2021 weight was not obtained as ordered.<br><br>Review of the facility's undated policy titled, Weight Policy and Procedure, revealed weights would be obtained at least monthly in order to identify those residents who may be at nutritional risk and require further evaluation and monitoring.<br><br>This deficiency substantiates Complaint Number OH00128640. |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>42015<br><br>Based on observation, interview, and record review, the facility failed to ensure sufficient dietary staff to timely serve meals to resident. This affected all 69 of 69 residents who received food and or drink from the kitchen. Resident #1, #7, #19, #1, #57, #73, and #75 received nothing by mouth.<br><br>Findings include:<br><br>Interview on 01/05/22 at 12:30 P.M. with Dietary Aide #138 revealed the facility did not have any cooks on this day (01/05/22) and has not had a dietary manager for a month. She revealed the maintenance supervisor and another maintenance worker have been helping out. She also revealed the Administrator has also been working in the kitchen a lot. She revealed meals have been late due to low kitchen staff.<br><br>Interview on 01/05/22 at 6:46 A.M. with STNA #124 revealed at times the kitchen does not have snacks for the STNA's to give to the residents due to the staffing issues in the kitchen.<br><br>Interview on 01/05/22 at 1:30 P.M. the Administrator confirmed lunch was delivered to the residents on Cascade Valley Hall one hour after its scheduled time.<br><br>Interviews on 01/05/22 from 10:30 A.M. to 10:40 A.M. with Residents #1, #15, #34 revealed the food was often brought late and was sometimes cold and doesn't taste good.<br><br>Interview on 01/10/22 at 12:19 P.M. with Resident #7, who is also the Resident council president, revealed meals are constantly delivered late due to low staffing. He reported this has been a concern brought up in resident council. He stated at times lunch was not served until after 2:00 P.M. and dinner is not served until after 6:00 P.M.<br><br>Observation of meal preparation on 01/05/22 at 12:43 P.M. revealed Dietary Aide #138 began plating trays for Cascade Valley. She completed plating all the trays at 1:10 P.M. The trays arrived on Cascade Valley at 1:15 P.M. Registered Nurse (RN) #105 and State tested Nursing Assistant (STNA) #111 completed passing all the trays by 1:30 P.M.<br><br>Review of the facility provided meal times sheet revealed meals for Cascade Valley Hall would be served as followed: breakfast 8:10 A.M. through 8:15 AM, lunch 12:10 P.M. through 12:15 P.M., and dinner 4:15 P.M. through 4:25 P.M.<br><br>Review of a list of resident diets revealed Resident #1, #7, #19, #1, #57, #73, and #75 received nothing by mouth.<br><br>Review of Resident Council meeting minutes for 11/17/21 and 12/15/21 revealed concerns with meals being delivered in late to residents.<br><br>This deficiency substantiates Complaint Number OH00128544. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015<br><br>Based on observation, interview, and record review, the facility failed to ensure proper infection control was maintained during incontinence care for Resident #54. This affected one resident (Resident #54) out of three residents reviewed for incontinence care.<br><br>Findings include:<br><br>Review of Resident #54 medical record revealed an admitted [DATE]. Diagnoses included dyspnea, hypertensive heart disease, and morbid obesity.<br><br>Review of Resident #54's quarterly Minimum Data Set (MDS) assessment, dated 10/25/21, revealed the residents was cognitively intact and was totally dependent of one person physical assist for personal hygiene, one person physical assistance for toileting, and was incontinent of bowel and bladder.<br><br>Observation on 01/05/22 at 8:20 A.M. revealed State tested Nursing Assistant (STNA) #111 positioned Resident #54 in bed, gathered supplies, washed her hands, put on gloves, and initiated incontinence care. STNA #111 cleansed the resident's genitalia and then rolled the resident to the side and cleansed her buttocks with a clean rag. STNA #111 then dried the resident's buttocks. With with the same gloves, STNA #111 opened a jar of incontinence cream, placed her gloved hand into the jar of cream, obtained a large amount of cream on her fingers, and covered the resident's buttocks with the cream. After Applying the cream, STNA #111 replaced resident's soiled incontinence brief with a clean brief, and repositioned the resident with the same soiled gloves she used to start incontinence care with. She then handed the resident her call light and replaced the lid on the jar of incontinence cream before removing her soiled gloves and washing her hands.<br><br>Interview on 01/05/22 at 8:37 A.M. with STNA #111 confirmed that she did not follow proper infection control procedures during incontinent care for Resident #54<br><br>Review of the undated facility policy titled, Hand washing, revealed facility staff should wash their hands after contact with resident bodily fluids, solid linen, or general cleaning.<br><br>This deficiency substantiates Complaint Number OH00128544. |