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 _____	09/16/2020

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 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, interview and record review the facility failed to ensure housekeeping staff wore the proper Personal Protective Equipment (PPE) while cleaning transmission-based precaution rooms. This affected two residents (Resident's #7 and #44) and had the potential to affect 33 residents (Resident's #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #13, #14, #15, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48 and #49) who resided on the Walnut and Cherry nursing units. The facility census was 47. Findings include: 1. Record review of Resident #7 revealed a readmission date of [DATE]. [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) 3.0 assessment was still progress. The resident's orders and nursing progress notes were silent in regard to infection or transmission-based precautions. Review of the order requisition dated 09/14/20 for Resident #7 COVID-19 test swab revealed the collection date was 09/14/20. Observation on 09/15/20 at 11:32 A.M. revealed a housekeeping cart outside of Resident #7's room located on the Cherry nursing unit, also the observation unit. Posted on the door of Resident #7's was a droplet contact precaution sign. Observation of Housekeeper (HSK) #300 exiting the resident's bathroom and come into the hall wearing a mask, face shield and gloves. HSK #300 removed the gloves and then the face shield. Interview at this time with HSK #300 confirmed she was supposed to have on a gown but did not. HSK #300 confirmed the sign posted on the door that read among the list of PPE, Gown before entering room. HSK #300 stated she was cleaning the bathroom and walked in there without the gown. Review of the facility's policy titled Guidance for Removal of Transmission-Based Precautions for COVID-19 Patients, undated, revealed for new admissions should remain isolated in the facility's observation area and in a private room for 14 days after admission or may be tested day seven or later after admission and moved off of observation unit after negative test results are received. 2. Record review of Resident #44 revealed a readmission date of [DATE]. [DIAGNOSES REDACTED]. The quarterly MDS 3.0 assessment dated [DATE] revealed the resident had an intact cognition and required extensive assistance of two staff for bed mobility, total dependence of two staff for transfers, and extensive assistance of one staff for toilet use. The resident also had an indwelling catheter and a multidrug resistant organism. Review of nursing notes were silent for infection. Review of the physician orders [REDACTED]. Review of the Care Plan dated 01/14/19 and revised on 10/29/19 for CRE in the urine. Intervention included isolation per protocols. Observation on 09/15/20 at 12:11 P.M. revealed a housekeeping cart outside of Resident #44's room, which was located on the Walnut nursing unit. Posted on the door of Resident #44's was an orange contact precautions sign. Observation of Housekeeper (HSK) #301 mopping the floor wearing a mask and gloves but no gown. Interview on 09/15/20 at 12:15 P.M. with HSK #301 confirmed she didn't wear gown while mopping the floor due to there wasn't a gown in the bin. HSK #301 stated usually she would ask nursing for gowns if there were none in the bin and they would get gowns. HSK #301 stated she normally wears a gown, but her mind was scattered today. Interview on 09/15/20 at 1:28 P.M. with Infection Control Preventionist (ICP) stated the signs on the door included what should be followed, and they should have worn the appropriate PPE. ICP stated Resident #44's room was an isolation room due to CRE in the urine, and the resident was a new admit and the resident's COVID-19 test was recently taken and awaiting results. ICP stated she wouldn't expect housekeeping to know clinically what's going on with the residents. Review of the facility's policy titled Transmission-Based Precautions Policy revised on 06/29/20 revealed under contact precautions, gowns are worn whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the resident. Under droplet precautions section it states gowns, gloves, eye protection are worn adhering to Standard Precaution guidelines.

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.