STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366317	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROMEDICA GOERLICH CENTER	**5320 HARROUN ROAD SYLVANIA, OH 43560**

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 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 observation, resident interview, review of resident record, and facility policy the facility failed to provide compression pump treatment as ordered. This affected one (Resident #27) of one resident reviewed for skin conditions. The facility census was 58. Findings include: Review of medical record for Resident #27 revealed an initial admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #27's most recent quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact. Review of Resident #27's physician orders revealed an order beginning 11/27/19 for [MEDICAL CONDITION] pump to right and left leg two times a day for one hour sessions. The physician order did not have an end date. Review of the Treatment Administration Record (TAR) for March 2020 revealed no treatments applied on 03/02/20, 03/03/20, 03/07/20, 03/08/20, 03/09/20, and 03/10/20. One treatment was applied on 03/05/20 and 03/06/20. During observation on 03/11/20 at 10:10 A.M, the resident had the compression pump on both legs. Resident #27 stated at the time of the observation the facility has not provided the treatment as frequently as ordered. She believed compression pumps were not applied the last two days and denied refusing the treatment. During interview on 03/11/20 at 2:21 P.M., Licensed Practical Nurse (LPN) #320 verified facility nurses apply the [MEDICAL CONDITION] pump to both legs as ordered and record the activity on the TAR. LPN #320 verified the treatment was not provided as ordered in March 2020. Review of the facility policy titled Medication and Treatment Administration Guidelines, updated March 2018, verified licensed nurses are oriented and evaluated annually in medication and treatment administration techniques and medication and treatment documentation requirements.
F 0686 **Level of harm** - Minimal harm or potential for 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, staff interview, observation and policy review, the facility failed to provide wound dressings as ordered. This affected one (Resident #8) of two reviewed for pressure ulcers. The facility identified seven residents with pressure ulcers. The census was 58. Findings include: Review of the medical record for Resident #8 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the care plan dated 12/26/19 for Resident #8's pressure ulcer revealed an intervention to administer treatments per physician order. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was moderately cognitively impaired, required extensive assistance with bed mobility, transferring, and toileting. Review of the physician order dated 02/13/20 for Resident #8 revealed an order to apply triad paste with a foam border dressing to the left buttock every 72 hours and as needed for soilage or removal. Review of the most recent skin assessment dated [DATE] revealed Resident #8 had a stage II pressure ulcer on his left buttock measuring approximately 1.5 centimeters (cm) long and 0.3 cm wide. The assessment referenced the treatment order for Triad cream and a foam border dressing to be completed three times a week and as needed. Interview on 03/10/20 at 3:55 P.M., with State tested Nursing Assistant (STNA) #310 revealed she was assigned to Resident #8 for the day and has toileted and changed the resident several times that day. The last time the resident was checked and changed was around 3:00 P.M. that day. She also revealed the resident has not had any dressings in place on his buttock for the entire day and was unaware one was to be on the resident. Observation on 03/10/20 at 5:15 P.M. with the Director of Nursing (DON) and STNA #310 revealed Resident #8 had a stage II pressure ulcer on the resident's inner left buttock. The wound was beefy red at the wound base, had no exposure of adipose tissue, no odor or drainage. There was no dressing in place at the time of observation. The DON verified at this time that Resident #8 should have a dressing covering the wound but there was not one in place. Review of the facility policy titled Dressing Changes, dated April 2016, revealed dressing changes are to be performed per physician orders.
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.** Based on interview, observation, material safety data sheet review, the facility failed to ensure hazardous chemicals were kept in locked storage on a secure dementia unit. This had the potential to affect three (Residents #43, #33, #47) who the facility identified as cognitively impaired, ambulatory, and reside in the Country Roads neighborhood. The facility census was 58. Findings include: Observation on 03/10/20 at 11:15 P.M. on the Country Roads secure dementia unit revealed an unlocked soiled utility closet. Inside the closet four chemicals were found stored in an unlocked cabinet. The chemicals found were one bottle of Wexcide 128 solution, one bottle of liquid fabric refresher, one bottle of liquid nail polish remover, and one can of aerosol disinfectant spray. All four bottles were full or partially full. There were no staff present in the area at the time of observation. Interview on 03/10/20 at 1:55 P.M. with Environmental Services Staff (EVS) #300 revealed that all chemicals should be in locked storage because of the residents who have dementia on all of the units. EVS #300 also stated that all of her chemicals are either kept in her locked storage area outside of the resident units or in the locked storage compartment on her cart. Observation at approximately 2:02 P.M. in the Country Roads neighborhood soiled utility room, EVS #300 verified the four chemicals were in unlocked storage and should have been moved or locked. Review of the Material Safety Data Sheets (MSDS) for Wexcide 128, liquid fabric refresher, aerosol disinfectant spray, and liquid nail polish remover revealed these chemicals had a risk for adverse health events.

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.