STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365814	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of camera video footage and facility policy review, the facility failed to ensure Resident #41 had appropriate transmission-based precautions implemented. This affected one (Resident #41) out of three residents reviewed for infection control. The facility census was 62.Findings include:Review of Resident #41's medical record revealed an admission date of 12/25/25 with diagnoses including dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, saddle embolus of pulmonary artery with acute cor pulmonale, urinary tract infection and extended spectrum beta lactamase (ESBL) resistance.Review of Resident #41's physician orders dated 12/25/25 revealed Contact Precautions/Isolation related to ESBL, every day shift and night shift. The orders were active from 12/25/25 through 01/29/26.Review of Resident #41's care plan dated 12/25/25 through 01/28/26 did not reveal evidence Resident #41 had a care plan related to Contact Precautions or Enhanced Barrier Precautions (EBP).Review of Resident #41's care plan dated 12/29/25 included Resident #41 had a problem with skin integrity and had a left elbow skin tear and left FA (forearm) basal cell carcinoma atypical wound. Resident #41's wounds would heal without complications. Interventions included treatment to left elbow per orders; and on 01/29/26 an intervention for EBP's every shift was initiated.Review of Resident #41's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 was unable to complete the interview. Resident #41 had impairment on one side of the upper extremity and impairment on both sides of the lower extremities. Resident #41 used a wheelchair and was dependent on staff for toileting and personal hygiene, dressing, bathing and bed mobility. Resident #41 was always incontinent of bowel and bladder. Resident #41 had a PEG (percutaneous endoscopic gastrostomy) feeding tube and received 51 percent or more total calories from tube feeding. Review of Resident #41's urine culture and sensitivity lab report revealed the urine specimen was collected on 01/08/26 and reported on 01/11/26. The report included there were two different groups of GNR (gram-negative rods, the most common cause of bacterial urinary tract infections (UTI's)), and the growth was less than 10,000 CFU (colony forming units) per milliliter, no work up.Review of Resident #41's progress notes dated 01/11/26 at 6:23 P.M. revealed Resident #41's urine culture results were finalized and faxed to Infectious Disease Physician (IDP) #400 and Primary Care Physician (PCP) #401.Review of Resident #41's medical record including physician orders and progress notes dated 01/11/26 through 01/29/26 did not reveal evidence Resident #41 was changed from Contact Precautions to EBP.Review of Resident #41's physician orders dated 01/15/26 revealed enteral-continuous tube feeding: Nutren 2.0 (interchanged with Isosource 1.5 at 40 milliliters per hour for 22 hours (off during ADL care) to provide 880 milliliters in a 24-hour period. Each shift should provide 440 milliliters until 880 total volume reached.Review of Resident #41's video camera footage dated 01/26/26 at about 8:31 A.M. revealed a nurse who appeared to be Licensed Practical Nurse (LPN) #327 was standing next to Resident #41's bed and she was administering medications via Resident #41's PEG tube, and LPN #327 was not (continued on next page)

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

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