

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Concord Care Center of Cortland		STREET ADDRESS, CITY, STATE, ZIP CODE 4250 Sodom Hutchings Rd 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on record review, interviews, review of the schedule and timecard punches, review of Ohio Department of Health Gateway, and review of the facility Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy, the facility failed to ensure residents were free from neglect when Agency Registered Nurse (RN) #607 left the facility for lunch on 09/15/24 for approximately 45 minutes with no other nurse on-site. In addition, when he left the facility, he left both medication carts unlocked and assessable to residents. This had the potential to affect all 32 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #12 revealed an admitted [DATE] and diagnoses included acute respiratory failure with hypoxia, hypertension, diabetes and low back pain. Review of Self-Medication assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #611 revealed Resident #12 did not want to self-administer her medication. All medication would be provided by nursing.</p> <p>Review of the care plan dated 08/21/23 revealed Resident #12 had hypertension. Interventions included giving anti-hypertension medications as ordered and monitoring, documenting, and reporting any signs of hypertension including headache, visual problems, confusion, lethargy, nausea and/or difficulty breathing.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #12 had intact cognition. She received scheduled pain medications to control her pain.</p> <p>Review of the care plan dated 08/23/24 revealed Resident #12 had actual pain related to arthritis, right foot neuropathy, back pain, and shoulder pain. Interventions included administering medications as ordered, evaluating effectiveness of pain interventions, and monitoring, recording, and reporting to the nurse any signs of pain.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the September 2024 physician's orders and September 2024 Medication Administration Record (MAR) revealed Resident #12 was to receive the following medication at 8:00 A.M.: buspirone 15 milligram (mg) by mouth twice a day every morning and bedtime for anxiety. She was to receive the following medications at 9:00 A.M. that included: Cozaar 100 mg tablet by mouth once a day for high blood pressure, Lidocaine patch five percent topically to lower back due to pain, Pristiq extended release 100 mg by mouth once a day for depression, and carvedilol 6.25 mg by mouth two times a day for high blood pressure with a meal. All of resident #12's medications scheduled for 09/15/24 from 8:00 A.M. to 6:00 P.M. were signed off as administered by Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #601 who was not working on 09/15/24.</p> <p>Review of daily staffing schedule and Daily Timecard dated 09/15/24 revealed Agency RN #607 punched in at 6:00 A.M. and punched out at 6:30 P.M. There were no recorded in or out time punches for lunch. He was the only nurse scheduled during this period.</p> <p>Review of Ohio Department of Health Gateway from 09/15/24 to 10/04/24 revealed no facility self-reported incident (SRI) was reported for neglect related to Agency RN #607 leaving the facility on 09/15/24 for lunch with no other nurse on-site.</p> <p>Interview on 10/04/24 at 8:35 A.M. with the Administrator revealed she was not aware of any time that the facility was left unattended without a nurse in the building, including on 09/15/24.</p> <p>Interview on 10/04/24 at 8:53 A.M. with Resident #6 revealed on 09/15/24 at approximately 11:30 A.M. Agency RN #607 left the facility and went to lunch leaving no nurse in the facility. He left both medication carts unlocked sitting in front of the nursing station. She observed Certified Nursing Assistant (CNA) #603 on the phone at the nursing station with ADON/ LPN #601 reporting that there was no nurse in the facility, and both medication carts were unlocked. ADON/ LPN #601 had asked CNA #603 to check the top drawer of each medication cart to see if Agency RN #607 left the keys to the carts inside of the top drawer as they were trying to determine if Agency RN #607 left the facility for the remainder of the day or just for lunch as he had not communicated with CNA #603 that he was leaving. Resident #6 revealed she went outside and observed Agency RN #607 return to the facility approximately 45 minutes later carrying a fast-food bag and a drink. Upon his return, Resident #12 asked him why he left the facility and asked what if something had happened while he was gone, and Agency RN #607 responded by stating, there was 911, which she felt was inconsiderate and rude. She stated Resident #12 was upset because she had not received her morning medications, and he left for lunch. Resident #6 believed that she was left in a dangerous and neglectful situation, and this was why she was getting out of the facility and going to a waiver setting. She reported the incident to the Ombudsman.</p> <p>Interview on 10/04/24 at 9:06 A.M. with the Director of Nursing (DON) revealed she was out of town on 09/15/24, and ADON/ LPN #601 covered any concerns at the facility. ADON/LPN #601 notified her that Agency RN #607 left the facility and went to lunch for approximately 45 minutes. She verified he left the facility without a licensed nurse on the premises as he was the only nurse on duty. She did not file an SRI with the state agency and/or complete an investigation regarding the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 9:19 A.M. with ADON/LPN #601 revealed she was at the facility on 09/15/24 at approximately 6:30 A.M. to provide Agency RN #607 with the layout of the building and his electronic medical record access because this was his first time at the facility. She did not educate Agency RN #607 that he was unable to leave the facility as she assumed he would know not to leave the building as the only nurse. She did not provide any other form of documentation/education regarding his job responsibilities. On 09/15/24 around lunchtime, she received a call at home from Housekeeping Supervisor #602 stating Agency RN #607 left the facility. She spoke with CNA #603 on the phone, who verified Agency RN #607 left the facility, and she was unsure if he had left for the remainder of the shift or just for lunch as he did not communicate that he was leaving the facility. She verified CNA #603 reported that Agency RN #607 left both medication carts unlocked. She had her check the top drawer of each cart to see if he left the keys inside. She left her house to drive to the facility which was approximately 25 minutes away. By the time she reached the facility, Agency RN #607 was back and told her he had gone for lunch. She said if she had to estimate, he left the facility for approximately 35 minutes. She spoke to him in the parking lot and told him that he was not permitted to leave the facility while on duty because he was the only nurse. She verified that CNA #603 stated several residents were upset that he left, including Residents #6 and #12. CNA #603 stated that the residents were upset because some of them had not received their morning medications, but she was unsure which residents had not received medications. She left the facility without coming in to speak with any of the residents and/or assess the situation. She felt since Agency RN #607 had returned that everything had calmed down. She reported the incident to the Administrator on 09/15/24. She also verified that Agency RN #607 was unable to sign off any of the medications that he administered and that she had signed them off even though she had not administered them.</p> <p>Interview on 10/04/24 at 9:37 A.M. with Resident #12 revealed on 09/15/24 at approximately 11:00 A.M. she had not received her morning medications (due at 8:00 A.M. and 9:00 A.M.) and went to the nursing station to see why she had not received them. Former Housekeeper #604 told her that Agency RN #607 left the facility, and there was no nurse on duty. She said she waited from 11:00 A.M. to 11:45 A.M. until he returned to the facility carrying a fast-food bag and a drink. She said she was upset that she had not received her morning medications, which included pain medication and medications for her blood pressure, and it was inappropriate for him to leave the facility with no nurse to go out for fast-food. She revealed she was to take blood pressure medication and was concerned that she had not received her medication because her mother had a massive stroke due to high blood pressure, and she did not want that to happen to her. She was also having pain in her back and left arm that morning that she rated at a seven on a pain scale of one to ten. She asked Agency RN #607 if his food was more important than the residents getting their medication, and he stated, yes it was. She told him it was against the law to leave a facility without a nurse, and he stated, I do not know anything about the law. She asked him what would happen if there was an emergency at the facility while he was gone, and he stated that that was what 911 was for. She believed that because she questioned him, he refused to give her medication until approximately 12:30 P.M.</p> <p>Interview on 10/04/24 at 9:55 A.M. with Housekeeping Supervisor #602 revealed she was not at the facility but received a call from Former Housekeeper #604 who was at the facility stating Agency RN #607 left the facility, and there was no nurse in the facility. She contacted ADON/ LPN #601 regarding the concern.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 10:05 A.M. with the Administrator revealed she wanted to clarify her previous statement as she was notified by ADON/ LPN #601 on 09/15/24 that Agency RN #607 left the facility, but she thought ADON/ LPN #601 was at the facility when he left and did not realize that there was not a nurse at the facility while he was gone. She verified she had not completed an SRI and/or investigation regarding the incident stating, I did not know it was an incident as I thought she was in the building until today, 10/04/24. She verified the incident could be considered resident neglect, but she would have to determine through an investigation, which was not completed.</p> <p>Telephone interview on 10/04/24 at 11:06 A.M. with Agency RN #607 revealed he was a travel nurse. He stated 09/15/24 was the only time he worked at the facility. It was very chaotic the whole time he was at the facility due to lack of staff. He stated that in the morning, ADON/ LPN #601 provided him with electronic medical record access but that he could only see what medications the residents were scheduled to get, and he could not sign them off as administered. Agency RN #607 revealed he had checked his blood sugar, and it was low, so he decided to go get some food at a local fast-food restaurant. He did not realize ADON/ LPN #601 had left the facility and/or that he was the only nurse in the facility. He stated he was gone for approximately 20 minutes. When he returned, a few residents (he could not remember their names) were upset that he had left. He stated he just got busy getting back to administering the medications. He verified he had not administered several of the resident's morning medications before he left for lunch. He was unsure of how many residents had not received their morning medications and/or what time he finished the morning medication administration. He was unable to remember the details of Resident #12, who was upset regarding him leaving the facility. He was unable to remember what he said to her and was unable to remember what time he administered her morning medications. He was unable to sign off any of the medications he administered on 09/15/24 as he could not get electronic monitoring access to allow him to. ADON/ LPN #601 told him that she would take care of it.</p> <p>Interview on 10/04/24 at 1:39 P.M. with the Administrator revealed if a nurse was unable to sign off on the electronic medical record, they should sign off on a hard copy of the MAR. The facility had previous internet disruptions, so all the current MARs were printed and in each resident's chart. She verified ADON/ LPN #601 should have directed Agency RN #607 to sign off the medications on the hard copy of the residents' MARs, and she should not have signed off the medications, especially because she did not administer the medications. Since ADON/ LPN #601 signed off all the medications, she had no documented evidence of the exact time Resident #12 received her morning medications on 09/15/24.</p> <p>Interview on 10/04/24 at 1:40 P.M. with Ombudsman #610 revealed on 09/19/24 she received a concern from Resident #6 that the only nurse that was scheduled at the facility on 09/15/24 left for lunch leaving the facility without a licensed nurse in the building. She reported Resident #6's concern to the DON on 09/20/24 and did not receive any follow-up as of today, 10/04/24, regarding the concern.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 1:51 P.M. with CNA #603 revealed on 09/15/24 at approximately 11:00 A.M., several residents were at the nursing station upset that they had not received their morning medications, and Agency RN #607 had left the facility leaving no nurse in the building. Approximately 45 minutes after Agency RN #607 left, he returned to the facility. Resident #12 was upset because he left, leaving the facility with no nurse, and she had not received her morning medications. Agency RN #607 did not notify her that he was leaving. She noticed both medication carts were unlocked with several residents up at the nursing station close to the medication carts. She received a call from ADON/ LPN #601 and informed her that Agency RN #607 left the facility, and both medication carts were unlocked. ADON/ LPN #601 had her check the top drawer of each cart to see if he had left the keys to try to determine if he left for the remainder of the shift or just for lunch. There were no keys found in the medication carts. Approximately 45 minutes later, Agency RN #607 returned to the facility, and Resident #12 was upset because he left the facility leaving the facility with no nurse and because she had not received her morning medications. CNA #603 stated, the whole situation was kind of scary, especially if there was an emergency.</p> <p>Residents #1, #3, #5, #11, and #28 were identified by the Administrator as being cognitively impaired and independently mobile putting them at greater risk of potentially obtaining unsecured medications from the unlocked medication carts.</p> <p>Review of the facility policy labeled, Abuse and Neglect- Clinical Protocol dated March 2018 revealed neglect was defined as the failure of the facility, its employee or service to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress. The staff with the physician input would investigate the alleged abuse and neglect to clarify what happened and identify possible causes. The physician would provide adequate documentation regarding significant negative outcomes.</p> <p>Review of the facility policy labeled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated April 2021 revealed residents have the right to be free from abuse, and neglect. The policy revealed to implement measures to address factors that may lead to abusive situations including preparing staff for caregiving responsibilities. The policy revealed the facility would identify and investigate all possible incidents of abuse, neglect and mistreatment. The facility would investigate and report any allegation within the timeframe required by federal requirement and protect residents from further harm during the investigation.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157987.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on record review, interview, review of schedule and timecard punches, review of Ohio Department of Health Gateway, and review of the facility Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy, the facility did implement their abuse and neglect policies including investigation and reporting an incident of resident neglect to the state agency after Agency Registered Nurse (RN) #607 left the facility on [DATE] for lunch, leaving no nurse at the facility for approximately 45 minutes. In addition, when he left the facility, he left both medication carts unlocked and assessable to residents. This had the potential to affect all 32 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #12 revealed an admitted [DATE] and diagnoses included acute respiratory failure with hypoxia, hypertension, diabetes and low back pain. Review of Self-Medication assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #611 revealed Resident #12 did not want to self-administer her medication. All medication would be provided by nursing.</p> <p>Review of the care plan dated 08/21/23 revealed Resident #12 had hypertension. Interventions included giving anti-hypertension medications as ordered and monitoring, documenting, and reporting any signs of hypertension including headache, visual problems, confusion, lethargy, nausea and/or difficulty breathing.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #12 had intact cognition. She received scheduled pain medications to control her pain.</p> <p>Review of the care plan dated 08/23/24 revealed Resident #12 had actual pain related to arthritis, right foot neuropathy, back pain, and shoulder pain. Interventions included administering medications as ordered, evaluating effectiveness of pain interventions, and monitoring, recording, and reporting to the nurse any signs of pain.</p> <p>Review of the September 2024 physician's orders and September 2024 Medication Administration Record (MAR) revealed Resident #12 was to receive the following medication at 8:00 A.M.: buspirone 15 milligram (mg) by mouth twice a day every morning and bedtime for anxiety. She was to receive the following medications at 9:00 A.M. that included: Cozaar 100 mg tablet by mouth once a day for high blood pressure, Lidocaine patch five percent topically to lower back due to pain, Pristiq extended release 100 mg by mouth once a day for depression, and carvedilol 6.25 mg by mouth two times a day for high blood pressure with a meal. All of resident #12's medications scheduled for 09/15/24 from 8:00 A.M. to 6:00 P.M. were signed off as administered by Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #601 who was not working on 09/15/24.</p> <p>Review of daily staffing schedule and Daily Timecard dated 09/15/24 revealed Agency RN #607 punched in at 6:00 A.M. and punched out at 6:30 P.M. There were no recorded in or out time punches for lunch. He was the only nurse scheduled during this period.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Ohio Department of Health Gateway from 09/15/24 to 10/04/24 revealed no facility self-reported incident (SRI) was reported for neglect related to Agency RN #607 leaving the facility on 09/15/24 for lunch with no other nurse on-site.</p> <p>Interview on 10/04/24 at 8:35 A.M. with the Administrator revealed she was not aware of any time that the facility was left unattended without a nurse in the building, including on 09/15/24.</p> <p>Interview on 10/04/24 at 8:53 A.M. with Resident #6 revealed on 09/15/24 at approximately 11:30 A.M. Agency RN #607 left the facility and went to lunch leaving no nurse in the facility. He left both medication carts unlocked sitting in front of the nursing station. She observed Certified Nursing Assistant (CNA) #603 on the phone at the nursing station with ADON/ LPN #601 reporting that there was no nurse in the facility, and both medication carts were unlocked. ADON/ LPN #601 had asked CNA #603 to check the top drawer of each medication cart to see if Agency RN #607 left the keys to the carts inside of the top drawer as they were trying to determine if Agency RN #607 left the facility for the remainder of the day or just for lunch as he had not communicated with CNA #603 that he was leaving. Resident #6 revealed she went outside and observed Agency RN #607 return to the facility approximately 45 minutes later carrying a fast-food bag and a drink. Upon his return, Resident #12 asked him why he left the facility and asked what if something had happened while he was gone, and Agency RN #607 responded by stating, there was 911, which she felt was inconsiderate and rude. She stated Resident #12 was upset because she had not received her morning medications, and he left for lunch. Resident #6 believed that she was left in a dangerous and neglectful situation, and this was why she was getting out of the facility and going to a waiver setting. She reported the incident to the Ombudsman.</p> <p>Interview on 10/04/24 at 9:06 A.M. with the Director of Nursing (DON) revealed she was out of town on 09/15/24, and ADON/ LPN #601 covered any concerns at the facility. ADON/LPN #601 notified her that Agency RN #607 left the facility and went to lunch for approximately 45 minutes. She verified he left the facility without a licensed nurse on the premises as he was the only nurse on duty. She did not file an SRI with the state agency and/or complete an investigation regarding the incident.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 9:19 A.M. with ADON/LPN #601 revealed she was at the facility on 09/15/24 at approximately 6:30 A.M. to provide Agency RN #607 with the layout of the building and his electronic medical record access because this was his first time at the facility. She did not educate Agency RN #607 that he was unable to leave the facility as she assumed he would know not to leave the building as the only nurse. She did not provide any other form of documentation/education regarding his job responsibilities. On 09/15/24 around lunchtime, she received a call at home from Housekeeping Supervisor #602 stating Agency RN #607 left the facility. She spoke with CNA #603 on the phone, who verified Agency RN #607 left the facility, and she was unsure if he had left for the remainder of the shift or just for lunch as he did not communicate that he was leaving the facility. She verified CNA #603 reported that Agency RN #607 left both medication carts unlocked. She had her check the top drawer of each cart to see if he left the keys inside. She left her house to drive to the facility which was approximately 25 minutes away. By the time she reached the facility, Agency RN #607 was back and told her he had gone for lunch. She said if she had to estimate, he left the facility for approximately 35 minutes. She spoke to him in the parking lot and told him that he was not permitted to leave the facility while on duty because he was the only nurse. She verified that CNA #603 stated several residents were upset that he left, including Residents #6 and #12. CNA #603 stated that the residents were upset because some of them had not received their morning medications, but she was unsure which residents had not received medications. She left the facility without coming in to speak with any of the residents and/or assess the situation. She felt since Agency RN #607 had returned that everything had calmed down. She reported the incident to the Administrator on 09/15/24. She also verified that Agency RN #607 was unable to sign off any of the medications that he administered and that she had signed them off even though she had not administered them.</p> <p>Interview on 10/04/24 at 9:37 A.M. with Resident #12 revealed on 09/15/24 at approximately 11:00 A.M. she had not received her morning medications (due at 8:00 A.M. and 9:00 A.M.) and went to the nursing station to see why she had not received them. Former Housekeeper #604 told her that Agency RN #607 left the facility, and there was no nurse on duty. She said she waited from 11:00 A.M. to 11:45 A.M. until he returned to the facility carrying a fast-food bag and a drink. She said she was upset that she had not received her morning medications, which included pain medication and medications for her blood pressure, and it was inappropriate for him to leave the facility with no nurse to go out for fast-food. She revealed she was to take blood pressure medication and was concerned that she had not received her medication because her mother had a massive stroke due to high blood pressure, and she did not want that to happen to her. She was also having pain in her back and left arm that morning that she rated at a seven on a pain scale of one to ten. She asked Agency RN #607 if his food was more important than the residents getting their medication, and he stated, yes it was. She told him it was against the law to leave a facility without a nurse, and he stated, I do not know anything about the law. She asked him what would happen if there was an emergency at the facility while he was gone, and he stated that that was what 911 was for. She believed that because she questioned him, he refused to give her medication until approximately 12:30 P.M.</p> <p>Interview on 10/04/24 at 9:55 A.M. with Housekeeping Supervisor #602 revealed she was not at the facility but received a call from Former Housekeeper #604 who was at the facility stating Agency RN #607 left the facility, and there was no nurse in the facility. She contacted ADON/ LPN #601 regarding the concern.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 10:05 A.M. with the Administrator revealed she wanted to clarify her previous statement as she was notified by ADON/ LPN #601 on 09/15/24 that Agency RN #607 left the facility, but she thought ADON/ LPN #601 was at the facility when he left and did not realize that there was not a nurse at the facility while he was gone. She verified she had not completed an SRI and/or investigation regarding the incident stating, I did not know it was an incident as I thought she was in the building until today, 10/04/24. She verified the incident could be considered resident neglect, but she would have to determine through an investigation, which was not completed.</p> <p>Telephone interview on 10/04/24 at 11:06 A.M. with Agency RN #607 revealed he was a travel nurse. He stated 09/15/24 was the only time he worked at the facility. It was very chaotic the whole time he was at the facility due to lack of staff. He stated that in the morning, ADON/ LPN #601 provided him with electronic medical record access but that he could only see what medications the residents were scheduled to get, and he could not sign them off as administered. Agency RN #607 revealed he had checked his blood sugar, and it was low, so he decided to go get some food at a local fast-food restaurant. He did not realize ADON/ LPN #601 had left the facility and/or that he was the only nurse in the facility. He stated he was gone for approximately 20 minutes. When he returned, a few residents (he could not remember their names) were upset that he had left. He stated he just got busy getting back to administering the medications. He verified he had not administered several of the resident's morning medications before he left for lunch. He was unsure of how many residents had not received their morning medications and/or what time he finished the morning medication administration. He was unable to remember the details of Resident #12, who was upset regarding him leaving the facility. He was unable to remember what he said to her and was unable to remember what time he administered her morning medications. He was unable to sign off any of the medications he administered on 09/15/24 as he could not get electronic monitoring access to allow him to. ADON/ LPN #601 told him that she would take care of it.</p> <p>Interview on 10/04/24 at 1:39 P.M. with the Administrator revealed if a nurse was unable to sign off on the electronic medical record, they should sign off on a hard copy of the MAR. The facility had previous internet disruptions, so all the current MARs were printed and in each resident's chart. She verified ADON/ LPN #601 should have directed Agency RN #607 to sign off the medications on the hard copy of the residents' MARs, and she should not have signed off the medications, especially because she did not administer the medications. Since ADON/ LPN #601 signed off all the medications, she had no documented evidence of the exact time Resident #12 received her morning medications on 09/15/24.</p> <p>Interview on 10/04/24 at 1:40 P.M. with Ombudsman #610 revealed on 09/19/24 she received a concern from Resident #6 that the only nurse that was scheduled at the facility on 09/15/24 left for lunch leaving the facility without a licensed nurse in the building. She reported Resident #6's concern to the DON on 09/20/24 and did not receive any follow-up as of today, 10/04/24, regarding the concern.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Concord Care Center of Cortland		STREET ADDRESS, CITY, STATE, ZIP CODE 4250 Sodom Hutchings Rd Cortland, OH 44410	
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 1:51 P.M. with CNA #603 revealed on 09/15/24 at approximately 11:00 A.M., several residents were at the nursing station upset that they had not received their morning medications, and Agency RN #607 had left the facility leaving no nurse in the building. Approximately 45 minutes after Agency RN #607 left, he returned to the facility. Resident #12 was upset because he left, leaving the facility with no nurse, and she had not received her morning medications. Agency RN #607 did not notify her that he was leaving. She noticed both medication carts were unlocked with several residents up at the nursing station close to the medication carts. She received a call from ADON/ LPN #601 and informed her that Agency RN #607 left the facility, and both medication carts were unlocked. ADON/ LPN #601 had her check the top drawer of each cart to see if he had left the keys to try to determine if he left for the remainder of the shift or just for lunch. There were no keys found in the medication carts. Approximately 45 minutes later, Agency RN #607 returned to the facility, and Resident #12 was upset because he left the facility leaving the facility with no nurse and because she had not received her morning medications. CNA #603 stated, the whole situation was kind of scary, especially if there was an emergency.</p> <p>Residents #1, #3, #5, #11, and #28 were identified by the Administrator as being cognitively impaired and independently mobile putting them at greater risk of potentially obtaining unsecured medications from the unlocked medication carts.</p> <p>Review of the facility policy labeled, Abuse and Neglect- Clinical Protocol dated March 2018 revealed neglect was defined as the failure of the facility, its employee or service to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress. The staff with the physician input would investigate the alleged abuse and neglect to clarify what happened and identify possible causes. The physician would provide adequate documentation regarding significant negative outcomes.</p> <p>Review of the facility policy labeled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated April 2021 revealed residents have the right to be free from abuse, and neglect. The policy revealed to implement measures to address factors that may lead to abusive situations including preparing staff for caregiving responsibilities. The policy revealed the facility would identify and investigate all possible incidents of abuse, neglect and mistreatment. The facility would investigate and report any allegation within the timeframe required by federal requirement and protect residents from further harm during the investigation.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157987.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on interview, review of schedule and timecard punches, review of Ohio Department of Health Gateway, and review of the facility Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, the facility failed to ensure an incident of staff-to-resident neglect was reported to the state survey agency after Agency Registered Nurse (RN) #607 left the facility on [DATE] for lunch, leaving no nurse at the facility for approximately 45 minutes. In addition, when he left the facility, he left both medication carts unlocked and assessable to residents. This had the potential to affect all 32 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of daily staffing schedule and Daily Timecard dated 09/15/24 revealed Agency RN #607 punched in at 6:00 A.M. and punched out at 6:30 P.M. There were no recorded in or out time punches for lunch. He was the only nurse scheduled during this period.</p> <p>Review of Ohio Department of Health Gateway from 09/15/24 to 10/04/24 revealed no facility self-reported incident (SRI) was reported for neglect related to Agency RN #607 leaving the facility on 09/15/24 for lunch with no other nurse on-site.</p> <p>Interview on 10/04/24 at 8:35 A.M. with the Administrator revealed she was not aware of any time that the facility was left unattended without a nurse in the building, including on 09/15/24.</p> <p>Interview on 10/04/24 at 8:53 A.M. with Resident #6 revealed on 09/15/24 at approximately 11:30 A.M. Agency RN #607 left the facility and went to lunch leaving no nurse in the facility. He left both medication carts unlocked sitting in front of the nursing station. She observed Certified Nursing Assistant (CNA) #603 on the phone at the nursing station with ADON/ LPN #601 reporting that there was no nurse in the facility, and both medication carts were unlocked. ADON/ LPN #601 had asked CNA #603 to check the top drawer of each medication cart to see if Agency RN #607 left the keys to the carts inside of the top drawer as they were trying to determine if Agency RN #607 left the facility for the remainder of the day or just for lunch as he had not communicated with CNA #603 that he was leaving. Resident #6 revealed she went outside and observed Agency RN #607 return to the facility approximately 45 minutes later carrying a fast-food bag and a drink. Upon his return, Resident #12 asked him why he left the facility and asked what if something had happened while he was gone, and Agency RN #607 responded by stating, there was 911, which she felt was inconsiderate and rude. She stated Resident #12 was upset because she had not received her morning medications, and he left for lunch. Resident #6 believed that she was left in a dangerous and neglectful situation, and this was why she was getting out of the facility and going to a waiver setting. She reported the incident to the Ombudsman.</p> <p>Interview on 10/04/24 at 9:06 A.M. with the Director of Nursing (DON) revealed she was out of town on 09/15/24, and ADON/ LPN #601 covered any concerns at the facility. ADON/LPN #601 notified her that Agency RN #607 left the facility and went to lunch for approximately 45 minutes. She verified he left the facility without a licensed nurse on the premises as he was the only nurse on duty. She did not file an SRI with the state agency and/or complete an investigation regarding the incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 9:19 A.M. with ADON/LPN #601 revealed she was at the facility on 09/15/24 at approximately 6:30 A.M. to provide Agency RN #607 with the layout of the building and his electronic medical record access because this was his first time at the facility. She did not educate Agency RN #607 that he was unable to leave the facility as she assumed he would know not to leave the building as the only nurse. She did not provide any other form of documentation/education regarding his job responsibilities. On 09/15/24 around lunchtime, she received a call at home from Housekeeping Supervisor #602 stating Agency RN #607 left the facility. She spoke with CNA #603 on the phone, who verified Agency RN #607 left the facility, and she was unsure if he had left for the remainder of the shift or just for lunch as he did not communicate that he was leaving the facility. She verified CNA #603 reported that Agency RN #607 left both medication carts unlocked. She had her check the top drawer of each cart to see if he left the keys inside. She left her house to drive to the facility which was approximately 25 minutes away. By the time she reached the facility, Agency RN #607 was back and told her he had gone for lunch. She said if she had to estimate, he left the facility for approximately 35 minutes. She spoke to him in the parking lot and told him that he was not permitted to leave the facility while on duty because he was the only nurse. She verified that CNA #603 stated several residents were upset that he left, including Residents #6 and #12. CNA #603 stated that the residents were upset because some of them had not received their morning medications, but she was unsure which residents had not received medications. She left the facility without coming in to speak with any of the residents and/or assess the situation. She felt since Agency RN #607 had returned that everything had calmed down. She reported the incident to the Administrator on 09/15/24. She also verified that Agency RN #607 was unable to sign off any of the medications that he administered and that she had signed them off even though she had not administered them.</p> <p>Interview on 10/04/24 at 9:37 A.M. with Resident #12 revealed on 09/15/24 at approximately 11:00 A.M. she had not received her morning medications (due at 8:00 A.M. and 9:00 A.M.) and went to the nursing station to see why she had not received them. Former Housekeeper #604 told her that Agency RN #607 left the facility, and there was no nurse on duty. She said she waited from 11:00 A.M. to 11:45 A.M. until he returned to the facility carrying a fast-food bag and a drink. She said she was upset that she had not received her morning medications, which included pain medication and medications for her blood pressure, and it was inappropriate for him to leave the facility with no nurse to go out for fast-food. She revealed she was to take blood pressure medication and was concerned that she had not received her medication because her mother had a massive stroke due to high blood pressure, and she did not want that to happen to her. She was also having pain in her back and left arm that morning that she rated at a seven on a pain scale of one to ten. She asked Agency RN #607 if his food was more important than the residents getting their medication, and he stated, yes it was. She told him it was against the law to leave a facility without a nurse, and he stated, I do not know anything about the law. She asked him what would happen if there was an emergency at the facility while he was gone, and he stated that that was what 911 was for. She believed that because she questioned him, he refused to give her medication until approximately 12:30 P.M.</p> <p>Interview on 10/04/24 at 9:55 A.M. with Housekeeping Supervisor #602 revealed she was not at the facility but received a call from Former Housekeeper #604 who was at the facility stating Agency RN #607 left the facility, and there was no nurse in the facility. She contacted ADON/ LPN #601 regarding the concern.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 10:05 A.M. with the Administrator revealed she wanted to clarify her previous statement as she was notified by ADON/ LPN #601 on 09/15/24 that Agency RN #607 left the facility, but she thought ADON/ LPN #601 was at the facility when he left and did not realize that there was not a nurse at the facility while he was gone. She verified she had not completed an SRI and/or investigation regarding the incident stating, I did not know it was an incident as I thought she was in the building until today, 10/04/24. She verified the incident could be considered resident neglect, but she would have to determine through an investigation, which was not completed.</p> <p>Telephone interview on 10/04/24 at 11:06 A.M. with Agency RN #607 revealed he was a travel nurse. He stated 09/15/24 was the only time he worked at the facility. It was very chaotic the whole time he was at the facility due to lack of staff. He stated that in the morning, ADON/ LPN #601 provided him with electronic medical record access but that he could only see what medications the residents were scheduled to get, and he could not sign them off as administered. Agency RN #607 revealed he had checked his blood sugar, and it was low, so he decided to go get some food at a local fast-food restaurant. He did not realize ADON/ LPN #601 had left the facility and/or that he was the only nurse in the facility. He stated he was gone for approximately 20 minutes. When he returned, a few residents (he could not remember their names) were upset that he had left. He stated he just got busy getting back to administering the medications. He verified he had not administered several of the resident's morning medications before he left for lunch. He was unsure of how many residents had not received their morning medications and/or what time he finished the morning medication administration. He was unable to remember the details of Resident #12, who was upset regarding him leaving the facility. He was unable to remember what he said to her and was unable to remember what time he administered her morning medications. He was unable to sign off any of the medications he administered on 09/15/24 as he could not get electronic monitoring access to allow him to. ADON/ LPN #601 told him that she would take care of it.</p> <p>Interview on 10/04/24 at 1:39 P.M. with the Administrator revealed if a nurse was unable to sign off on the electronic medical record, they should sign off on a hard copy of the MAR. The facility had previous internet disruptions, so all the current MARs were printed and in each resident's chart. She verified ADON/ LPN #601 should have directed Agency RN #607 to sign off the medications on the hard copy of the residents' MARs, and she should not have signed off the medications, especially because she did not administer the medications. Since ADON/ LPN #601 signed off all the medications, she had no documented evidence of the exact time Resident #12 received her morning medications on 09/15/24.</p> <p>Interview on 10/04/24 at 1:40 P.M. with Ombudsman #610 revealed on 09/19/24 she received a concern from Resident #6 that the only nurse that was scheduled at the facility on 09/15/24 left for lunch leaving the facility without a licensed nurse in the building. She reported Resident #6's concern to the DON on 09/20/24 and did not receive any follow-up as of today, 10/04/24, regarding the concern.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 1:51 P.M. with CNA #603 revealed on 09/15/24 at approximately 11:00 A.M., several residents were at the nursing station upset that they had not received their morning medications, and Agency RN #607 had left the facility leaving no nurse in the building. Approximately 45 minutes after Agency RN #607 left, he returned to the facility. Resident #12 was upset because he left, leaving the facility with no nurse, and she had not received her morning medications. Agency RN #607 did not notify her that he was leaving. She noticed both medication carts were unlocked with several residents up at the nursing station close to the medication carts. She received a call from ADON/ LPN #601 and informed her that Agency RN #607 left the facility, and both medication carts were unlocked. ADON/ LPN #601 had her check the top drawer of each cart to see if he had left the keys to try to determine if he left for the remainder of the shift or just for lunch. There were no keys found in the medication carts. Approximately 45 minutes later, Agency RN #607 returned to the facility, and Resident #12 was upset because he left the facility leaving the facility with no nurse and because she had not received her morning medications. CNA #603 stated, the whole situation was kind of scary, especially if there was an emergency.</p> <p>Residents #1, #3, #5, #11, and #28 were identified by the Administrator as being cognitively impaired and independently mobile putting them at greater risk of potentially obtaining unsecured medications from the unlocked medication carts.</p> <p>Review of facility policy, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated September 2022 revealed all reports of resident abuse, neglect, exploitation, or misappropriation would be reported to local, state, and federal agencies as required by current regulation and thoroughly investigated by the facility management. The policy revealed all investigations were to be documented and reported. The administrator would immediately report his or her suspicion to the following persons or agencies including the state licensing/certification agency responsible for surveying/ licensing the facility, attending physician and medical director.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157987.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on interview, review of timecard punches, review of Ohio Department of Health Gateway, and review of the Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy, the facility failed to ensure an incident of staff-to-resident neglect was thoroughly investigated after Agency Registered Nurse (RN) #607 left the facility on [DATE] for lunch, leaving no nurse at the facility for approximately 45 minutes. In addition, when he left the facility, he left both medication carts unlocked and assessable to residents. This had the potential to affect all 32 residents residing in the facility.</p> <p>Findings included:</p> <p>Review of daily staffing schedule and Daily Timecard dated 09/15/24 revealed Agency RN #607 punched in at 6:00 A.M. and punched out at 6:30 P.M. There were no recorded in or out time punches for lunch. He was the only nurse scheduled during this period.</p> <p>Review of Ohio Department of Health Gateway from 09/15/24 to 10/04/24 revealed no facility self-reported incident (SRI) was reported for neglect related to Agency RN #607 leaving the facility on 09/15/24 for lunch with no other nurse on-site.</p> <p>Interview on 10/04/24 at 8:35 A.M. with the Administrator revealed she was not aware of any time that the facility was left unattended without a nurse in the building, including on 09/15/24.</p> <p>Interview on 10/04/24 at 8:53 A.M. with Resident #6 revealed on 09/15/24 at approximately 11:30 A.M. Agency RN #607 left the facility and went to lunch leaving no nurse in the facility. He left both medication carts unlocked sitting in front of the nursing station. She observed Certified Nursing Assistant (CNA) #603 on the phone at the nursing station with ADON/ LPN #601 reporting that there was no nurse in the facility, and both medication carts were unlocked. ADON/ LPN #601 had asked CNA #603 to check the top drawer of each medication cart to see if Agency RN #607 left the keys to the carts inside of the top drawer as they were trying to determine if Agency RN #607 left the facility for the remainder of the day or just for lunch as he had not communicated with CNA #603 that he was leaving. Resident #6 revealed she went outside and observed Agency RN #607 return to the facility approximately 45 minutes later carrying a fast-food bag and a drink. Upon his return, Resident #12 asked him why he left the facility and asked what if something had happened while he was gone, and Agency RN #607 responded by stating, there was 911, which she felt was inconsiderate and rude. She stated Resident #12 was upset because she had not received her morning medications, and he left for lunch. Resident #6 believed that she was left in a dangerous and neglectful situation, and this was why she was getting out of the facility and going to a waiver setting. She reported the incident to the Ombudsman.</p> <p>Interview on 10/04/24 at 9:06 A.M. with the Director of Nursing (DON) revealed she was out of town on 09/15/24, and ADON/ LPN #601 covered any concerns at the facility. ADON/LPN #601 notified her that Agency RN #607 left the facility and went to lunch for approximately 45 minutes. She verified he left the facility without a licensed nurse on the premises as he was the only nurse on duty. She did not file an SRI with the state agency and/or complete an investigation regarding the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 9:19 A.M. with ADON/LPN #601 revealed she was at the facility on 09/15/24 at approximately 6:30 A.M. to provide Agency RN #607 with the layout of the building and his electronic medical record access because this was his first time at the facility. She did not educate Agency RN #607 that he was unable to leave the facility as she assumed he would know not to leave the building as the only nurse. She did not provide any other form of documentation/education regarding his job responsibilities. On 09/15/24 around lunchtime, she received a call at home from Housekeeping Supervisor #602 stating Agency RN #607 left the facility. She spoke with CNA #603 on the phone, who verified Agency RN #607 left the facility, and she was unsure if he had left for the remainder of the shift or just for lunch as he did not communicate that he was leaving the facility. She verified CNA #603 reported that Agency RN #607 left both medication carts unlocked. She had her check the top drawer of each cart to see if he left the keys inside. She left her house to drive to the facility which was approximately 25 minutes away. By the time she reached the facility, Agency RN #607 was back and told her he had gone for lunch. She said if she had to estimate, he left the facility for approximately 35 minutes. She spoke to him in the parking lot and told him that he was not permitted to leave the facility while on duty because he was the only nurse. She verified that CNA #603 stated several residents were upset that he left, including Residents #6 and #12. CNA #603 stated that the residents were upset because some of them had not received their morning medications, but she was unsure which residents had not received medications. She left the facility without coming in to speak with any of the residents and/or assess the situation. She felt since Agency RN #607 had returned that everything had calmed down. She reported the incident to the Administrator on 09/15/24. She also verified that Agency RN #607 was unable to sign off any of the medications that he administered and that she had signed them off even though she had not administered them.</p> <p>Interview on 10/04/24 at 9:37 A.M. with Resident #12 revealed on 09/15/24 at approximately 11:00 A.M. she had not received her morning medications (due at 8:00 A.M. and 9:00 A.M.) and went to the nursing station to see why she had not received them. Former Housekeeper #604 told her that Agency RN #607 left the facility, and there was no nurse on duty. She said she waited from 11:00 A.M. to 11:45 A.M. until he returned to the facility carrying a fast-food bag and a drink. She said she was upset that she had not received her morning medications, which included pain medication and medications for her blood pressure, and it was inappropriate for him to leave the facility with no nurse to go out for fast-food. She revealed she was to take blood pressure medication and was concerned that she had not received her medication because her mother had a massive stroke due to high blood pressure, and she did not want that to happen to her. She was also having pain in her back and left arm that morning that she rated at a seven on a pain scale of one to ten. She asked Agency RN #607 if his food was more important than the residents getting their medication, and he stated, yes it was. She told him it was against the law to leave a facility without a nurse, and he stated, I do not know anything about the law. She asked him what would happen if there was an emergency at the facility while he was gone, and he stated that that was what 911 was for. She believed that because she questioned him, he refused to give her medication until approximately 12:30 P.M.</p> <p>Interview on 10/04/24 at 9:55 A.M. with Housekeeping Supervisor #602 revealed she was not at the facility but received a call from Former Housekeeper #604 who was at the facility stating Agency RN #607 left the facility, and there was no nurse in the facility. She contacted ADON/ LPN #601 regarding the concern.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Concord Care Center of Cortland		STREET ADDRESS, CITY, STATE, ZIP CODE 4250 Sodom Hutchings Rd 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.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 10:05 A.M. with the Administrator revealed she wanted to clarify her previous statement as she was notified by ADON/ LPN #601 on 09/15/24 that Agency RN #607 left the facility, but she thought ADON/ LPN #601 was at the facility when he left and did not realize that there was not a nurse at the facility while he was gone. She verified she had not completed an SRI and/or investigation regarding the incident stating, I did not know it was an incident as I thought she was in the building until today, 10/04/24. She verified the incident could be considered resident neglect, but she would have to determine through an investigation, which was not completed.</p> <p>Telephone interview on 10/04/24 at 11:06 A.M. with Agency RN #607 revealed he was a travel nurse. He stated 09/15/24 was the only time he worked at the facility. It was very chaotic the whole time he was at the facility due to lack of staff. He stated that in the morning, ADON/ LPN #601 provided him with electronic medical record access but that he could only see what medications the residents were scheduled to get, and he could not sign them off as administered. Agency RN #607 revealed he had checked his blood sugar, and it was low, so he decided to go get some food at a local fast-food restaurant. He did not realize ADON/ LPN #601 had left the facility and/or that he was the only nurse in the facility. He stated he was gone for approximately 20 minutes. When he returned, a few residents (he could not remember their names) were upset that he had left. He stated he just got busy getting back to administering the medications. He verified he had not administered several of the resident's morning medications before he left for lunch. He was unsure of how many residents had not received their morning medications and/or what time he finished the morning medication administration. He was unable to remember the details of Resident #12, who was upset regarding him leaving the facility. He was unable to remember what he said to her and was unable to remember what time he administered her morning medications. He was unable to sign off any of the medications he administered on 09/15/24 as he could not get electronic monitoring access to allow him to. ADON/ LPN #601 told him that she would take care of it.</p> <p>Interview on 10/04/24 at 1:39 P.M. with the Administrator revealed if a nurse was unable to sign off on the electronic medical record, they should sign off on a hard copy of the MAR. The facility had previous internet disruptions, so all the current MARs were printed and in each resident's chart. She verified ADON/ LPN #601 should have directed Agency RN #607 to sign off the medications on the hard copy of the residents' MARs, and she should not have signed off the medications, especially because she did not administer the medications. Since ADON/ LPN #601 signed off all the medications, she had no documented evidence of the exact time Resident #12 received her morning medications on 09/15/24.</p> <p>Interview on 10/04/24 at 1:40 P.M. with Ombudsman #610 revealed on 09/19/24 she received a concern from Resident #6 that the only nurse that was scheduled at the facility on 09/15/24 left for lunch leaving the facility without a licensed nurse in the building. She reported Resident #6's concern to the DON on 09/20/24 and did not receive any follow-up as of today, 10/04/24, regarding the concern.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 1:51 P.M. with CNA #603 revealed on 09/15/24 at approximately 11:00 A.M., several residents were at the nursing station upset that they had not received their morning medications, and Agency RN #607 had left the facility leaving no nurse in the building. Approximately 45 minutes after Agency RN #607 left, he returned to the facility. Resident #12 was upset because he left, leaving the facility with no nurse, and she had not received her morning medications. Agency RN #607 did not notify her that he was leaving. She noticed both medication carts were unlocked with several residents up at the nursing station close to the medication carts. She received a call from ADON/ LPN #601 and informed her that Agency RN #607 left the facility, and both medication carts were unlocked. ADON/ LPN #601 had her check the top drawer of each cart to see if he had left the keys to try to determine if he left for the remainder of the shift or just for lunch. There were no keys found in the medication carts. Approximately 45 minutes later, Agency RN #607 returned to the facility, and Resident #12 was upset because he left the facility leaving the facility with no nurse and because she had not received her morning medications. CNA #603 stated, the whole situation was kind of scary, especially if there was an emergency.</p> <p>Residents #1, #3, #5, #11, and #28 were identified by the Administrator as being cognitively impaired and independently mobile putting them at greater risk of potentially obtaining unsecured medications from the unlocked medication carts.</p> <p>Review of the facility policy, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated April 2021 revealed residents have the right to be free from abuse, and neglect. The policy revealed to implement measures to address factors that may lead to abusive situations including preparing staff for caregiving responsibilities. The policy revealed the facility would identify and investigate all possible incidents of abuse, neglect, and mistreatment.</p> <p>Review of the facility policy, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated September 2022 revealed all reports of resident abuse, neglect, exploitation, or misappropriation would be thoroughly investigated by the facility management. The policy revealed all allegations would be thoroughly investigated. The individual conducting the investigation would review the documentation and evidence, review resident's medical records, observe the alleged victim, interview the person reporting the incident, interview any witnesses, and interview any staff members that were on during the alleged incident. Upon conclusion of the investigation the investigator would record the findings of the investigation. The policy revealed within five business days of the incident and the administrator would provide a follow-up investigation.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157987.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>39973</p> <p>Based on interviews, review of the schedule and timecard punches, review of the staffing tool, and review of the facility assessment, the facility failed to ensure sufficient nursing staff, including on 09/15/24 when Agency Registered Nurse (RN) #607 left the facility for lunch resulting in no nurse at the facility. The facility also failed to meet the daily direct care requirement of 2.50 hours per resident on 09/15/24 and 09/21/24. This had the potential to affect all 32 residents residing in the facility.</p> <p>Findings included:</p> <p>1. Review of daily staffing schedule and Daily Timecard dated 09/15/24 revealed Agency RN #607 punched in at 6:00 A.M. and punched out at 6:30 P.M. There were no recorded in or out time punches for lunch. He was the only nurse scheduled during this period.</p> <p>Interview on 10/04/24 at 8:35 A.M. with the Administrator revealed she was not aware of any time that the facility was left unattended without a nurse in the building, including on 09/15/24.</p> <p>Interview on 10/04/24 at 8:53 A.M. with Resident #6 revealed on 09/15/24 at approximately 11:30 A.M. Agency RN #607 left the facility and went to lunch leaving no nurse in the facility. He left both medication carts unlocked sitting in front of the nursing station. She observed Certified Nursing Assistant (CNA) #603 on the phone at the nursing station with ADON/ LPN #601 reporting that there was no nurse in the facility, and both medication carts were unlocked. Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #601 had asked CNA #603 to check the top drawer of each medication cart to see if Agency RN #607 left the keys to the carts inside of the top drawer as they were trying to determine if Agency RN #607 left the facility for the remainder of the day or just for lunch as he had not communicated with CNA #603 that he was leaving. Resident #6 revealed she went outside and observed Agency RN #607 return to the facility approximately 45 minutes later carrying a fast-food bag and a drink. Upon his return, Resident #12 asked him why he left the facility and asked what if something had happened while he was gone, and Agency RN #607 responded by stating, there was 911, which she felt was inconsiderate and rude. She stated Resident #12 was upset because she had not received her morning medications, and he left for lunch. Resident #6 believed that she was left in a dangerous and neglectful situation, and this was why she was getting out of the facility and going to a waiver setting. She reported the incident to the Ombudsman.</p> <p>Interview on 10/04/24 at 9:06 A.M. with the Director of Nursing (DON) revealed she was out of town on 09/15/24, and ADON/LPN #601 covered any concerns at the facility. ADON/LPN #601 notified her that Agency RN #607 left the facility and went to lunch for approximately 45 minutes. She verified he left the facility without a licensed nurse on the premises as he was the only nurse on duty. She did not file an SRI with the state agency and/or complete an investigation regarding the incident.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 10:05 A.M. with the Administrator revealed she wanted to clarify her previous statement as she was notified by ADON/ LPN #601 on 09/15/24 that Agency RN #607 left the facility, but she thought ADON/ LPN #601 was at the facility when he left and did not realize that there was not a nurse at the facility while he was gone. She verified she had not completed an SRI and/or investigation regarding the incident stating, I did not know it was an incident as I thought she was in the building until today, 10/04/24. She verified the incident could be considered resident neglect, but she would have to determine through an investigation, which was not completed.</p> <p>Telephone interview on 10/04/24 at 11:06 A.M. with Agency RN #607 revealed he was a travel nurse. He stated 09/15/24 was the only time he worked at the facility. It was very chaotic the whole time he was at the facility due to lack of staff. He stated that in the morning, ADON/ LPN #601 provided him with electronic medical record access but that he could only see what medications the residents were scheduled to get, and he could not sign them off as administered. Agency RN #607 revealed he had checked his blood sugar, and it was low, so he decided to go get some food at a local fast-food restaurant. He did not realize ADON/ LPN #601 had left the facility and/or that he was the only nurse in the facility. He stated he was gone for approximately 20 minutes. When he returned, a few residents (he could not remember their names) were upset that he had left. He stated he just got busy getting back to administering the medications. He verified he had not administered several of the resident's morning medications before he left for lunch. He was unsure of how many residents had not received their morning medications and/or what time he finished the morning medication administration. He was unable to remember the details of Resident #12, who was upset regarding him leaving the facility. He was unable to remember what he said to her and was unable to remember what time he administered her morning medications. He was unable to sign off any of the medications he administered on 09/15/24 as he could not get electronic monitoring access to allow him to. ADON/ LPN #601 told him that she would take care of it.</p> <p>Interview on 10/04/24 at 1:40 P.M. with Ombudsman #610 revealed on 09/19/24 she received a concern from Resident #6 that the only nurse that was scheduled at the facility on 09/15/24 left for lunch leaving the facility without a licensed nurse in the building. She reported Resident #6's concern to the DON on 09/20/24 and did not receive any follow-up as of today, 10/04/24, regarding the concern.</p> <p>Interview on 10/04/24 at 1:51 P.M. with CNA #603 revealed on 09/15/24 at approximately 11:00 A.M., several residents were at the nursing station upset that they had not received their morning medications, and Agency RN #607 had left the facility leaving no nurse in the building. Approximately 45 minutes after Agency RN #607 left, he returned to the facility. Resident #12 was upset because he left, leaving the facility with no nurse, and she had not received her morning medications. Agency RN #607 did not notify her that he was leaving. She noticed both medication carts were unlocked with several residents up at the nursing station close to the medication carts. She received a call from ADON/ LPN #601 and informed her that Agency RN #607 left the facility, and both medication carts were unlocked. ADON/ LPN #601 had her check the top drawer of each cart to see if he had left the keys to try to determine if he left for the remainder of the shift or just for lunch. There were no keys found in the medication carts. Approximately 45 minutes later, Agency RN #607 returned to the facility, and Resident #12 was upset because he left the facility leaving the facility with no nurse and because she had not received her morning medications. CNA #603 stated, the whole situation was kind of scary, especially if there was an emergency.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Review of the staffing tool dated from 09/15/24 to 09/21/24 with the Administrator revealed on 09/15/24 the facility did not meet the minimum daily direct care requirement of 2.50 hours per resident as they only had 2.35 hours per resident. On 09/21/24, the facility did not meet the minimum daily direct care requirement as they only had 2.42 hours per resident.</p> <p>Interview on 10/04/24 at 11:06 A.M. with Agency RN #607 revealed on 09/15/24 he felt the facility was very understaffed because most of the shift there was only one aide. He stated she worked like a dog: trying to get everything done. He verified he had not administered several of the resident's morning medications before he left for lunch. He was unsure how many residents had not received their morning medications and/or what time he finished the morning medication administration. He verified the medications were administered late. He had 30 residents to administer medications to, and he felt this was not possible to complete in the time frame allotted, especially because he was unfamiliar with the residents because it was his first day at the facility.</p> <p>Interview on 10/04/24 at 11:15 A.M. with the Administrator revealed the facility assessment tool indicated they would have two nurses and four aides per day, which she stated would be one nurse and two aides per twelve-hour shift. She verified the facility did not meet the minimum daily direct care requirement of 2.50 hours per resident as on 09/15/24 as the facility only had 2.35 hours per resident, and on 09/21/24, they only had 2.42 hours per resident. She verified on 09/15/24 there was only one aide from 6:00 A.M. to 11:00 A.M. to care for 30 residents. They only added a second nurse on duty if the census was 32 or above even if the one nurse was agency and not familiar with the residents.</p> <p>Interview on 10/04/24 at 1:51 P.M. with CNA #603 revealed on 09/15/24 she was the only CNA on duty until 11:00 A.M. when CNA #609 came in. She revealed resident care was delayed by an hour or two, including completing incontinence rounds and getting residents up, especially since she had four residents that required feeding assistance at breakfast, and she had 30 residents to provide care for.</p> <p>Review of the Facility Assessment Tool dated 07/26/24 revealed the average census was 25, and the facility staffing plan was to have two nurses and four aides per day.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157987 and Complaint Number OH00157157.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on interview, record review, and review of the facility policy, the facility failed to ensure there was sufficient nursing staff with appropriate competencies to provide nursing services to ensure resident safety, including when Agency Registered Nurse (RN) #607 left the facility on [DATE] for lunch, leaving no nurse at the facility for approximately 45 minutes. When Agency RN #607 left the facility, he left both medication carts unlocked and assessable to residents. In addition, Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #601 signed that she administered all medications on 09/15/24 from 6:00 A.M. to 6:00 P.M. despite not working on 09/15/24. This had the potential to affect all 32 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Review of the agency contract dated 06/20/23 revealed the facility acknowledged and agreed that the facility was solely responsible for management of patient care and professional providers provision of healthcare services during a shift with the agency personnel. There was nothing in the contract regarding whether the agency would be trained to ensure job responsibilities would be conveyed to the agency personnel.</p> <p>Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, hypertension, diabetes and low back pain. Review of Self-Medication assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #611 revealed Resident #12 did not want to self-administer her medication. All medication would be provided by nursing.</p> <p>Review of the care plan dated 08/21/23 revealed Resident #12 had hypertension. Interventions included giving anti-hypertension medications as ordered and monitoring, documenting, and reporting any signs of hypertension including headache, visual problems, confusion, lethargy, nausea and/or difficulty breathing.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #12 had intact cognition. She received scheduled pain medications to control her pain.</p> <p>Review of the care plan dated 08/23/24 revealed Resident #12 had actual pain related to arthritis, right foot neuropathy, back pain, and shoulder pain. Interventions included administering medications as ordered, evaluating effectiveness of pain interventions, and monitoring, recording, and reporting to the nurse any signs of pain.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the September 2024 physician's orders and September 2024 Medication Administration Record (MAR) revealed Resident #12 was to receive the following medication at 8:00 A.M.: buspirone 15 milligram (mg) by mouth twice a day every morning and bedtime for anxiety. She was to receive the following medications at 9:00 A.M. that included: Cozaar 100 mg tablet by mouth once a day for high blood pressure, Lidocaine patch five percent topically to lower back due to pain, Pristiq extended release 100 mg by mouth once a day for depression, and carvedilol 6.25 mg by mouth two times a day for high blood pressure with a meal. All of resident #12's medications scheduled for 09/15/24 from 8:00 A.M. to 6:00 P.M. were signed off as administered by Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #601 who was not working on 09/15/24.</p> <p>Review of the daily staffing schedule and Daily Timecard dated 09/15/24 revealed Agency RN #607 punched in at 6:00 A.M. and punched out at 6:30 P.M. There were no recorded in or out time punches for lunch. He was the only nurse scheduled during this period.</p> <p>Interview on 10/04/24 at 8:35 A.M. with the Administrator revealed she was not aware of any time that the facility was left unattended without a nurse in the building, including on 09/15/24.</p> <p>Interview on 10/04/24 at 8:53 A.M. with Resident #6 revealed on 09/15/24 at approximately 11:30 A.M. Agency RN #607 left the facility and went to lunch leaving no nurse in the facility. He left both medication carts unlocked sitting in front of the nursing station. She observed Certified Nursing Assistant (CNA) #603 on the phone at the nursing station with ADON/ LPN #601 reporting that there was no nurse in the facility, and both medication carts were unlocked. ADON/ LPN #601 had asked CNA #603 to check the top drawer of each medication cart to see if Agency RN #607 left the keys to the carts inside of the top drawer as they were trying to determine if Agency RN #607 left the facility for the remainder of the day or just for lunch as he had not communicated with CNA #603 that he was leaving. Resident #6 revealed she went outside and observed Agency RN #607 return to the facility approximately 45 minutes later carrying a fast-food bag and a drink. Upon his return, Resident #12 asked him why he left the facility and asked what if something had happened while he was gone, and Agency RN #607 responded by stating, there was 911, which she felt was inconsiderate and rude. She stated Resident #12 was upset because she had not received her morning medications, and he left for lunch. Resident #6 believed that she was left in a dangerous and neglectful situation, and this was why she was getting out of the facility and going to a waiver setting. She reported the incident to the Ombudsman.</p> <p>Interview on 10/04/24 at 9:06 A.M. with the Director of Nursing (DON) revealed she was out of town on 09/15/24, and ADON/ LPN #601 covered any concerns at the facility. ADON/LPN #601 notified her that Agency RN #607 left the facility and went to lunch for approximately 45 minutes. She verified he left the facility without a licensed nurse on the premises as he was the only nurse on duty. She did not file an SRI with the state agency and/or complete an investigation regarding the incident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Concord Care Center of Cortland		STREET ADDRESS, CITY, STATE, ZIP CODE 4250 Sodom Hutchings Rd Cortland, OH 44410	
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 9:19 A.M. with ADON/LPN #601 revealed she was at the facility on 09/15/24 at approximately 6:30 A.M. to provide Agency RN #607 with the layout of the building and his electronic medical record access because this was his first time at the facility. She did not educate Agency RN #607 that he was unable to leave the facility as she assumed he would know not to leave the building as the only nurse. She did not provide any other form of documentation/education regarding his job responsibilities. On 09/15/24 around lunchtime, she received a call at home from Housekeeping Supervisor #602 stating Agency RN #607 left the facility. She spoke with CNA #603 on the phone, who verified Agency RN #607 left the facility, and she was unsure if he had left for the remainder of the shift or just for lunch as he did not communicate that he was leaving the facility. She verified CNA #603 reported that Agency RN #607 left both medication carts unlocked. She had her check the top drawer of each cart to see if he left the keys inside. She left her house to drive to the facility which was approximately 25 minutes away. By the time she reached the facility, Agency RN #607 was back and told her he had gone for lunch. She said if she had to estimate, he left the facility for approximately 35 minutes. She spoke to him in the parking lot and told him that he was not permitted to leave the facility while on duty because he was the only nurse. She verified that CNA #603 stated several residents were upset that he left, including Residents #6 and #12. CNA #603 stated that the residents were upset because some of them had not received their morning medications, but she was unsure which residents had not received medications. She left the facility without coming in to speak with any of the residents and/or assess the situation. She felt since Agency RN #607 had returned that everything had calmed down. She reported the incident to the Administrator on 09/15/24. She also verified that Agency RN #607 was unable to sign off any of the medications that he administered and that she had signed them off even though she had not administered them.</p> <p>Interview on 10/04/24 at 9:37 A.M. with Resident #12 revealed on 09/15/24 at approximately 11:00 A.M. she had not received her morning medications (due at 8:00 A.M. and 9:00 A.M.) and went to the nursing station to see why she had not received them. Former Housekeeper #604 told her that Agency RN #607 left the facility, and there was no nurse on duty. She said she waited from 11:00 A.M. to 11:45 A.M. until he returned to the facility carrying a fast-food bag and a drink. She said she was upset that she had not received her morning medications, which included pain medication and medications for her blood pressure, and it was inappropriate for him to leave the facility with no nurse to go out for fast-food. She revealed she was to take blood pressure medication and was concerned that she had not received her medication because her mother had a massive stroke due to high blood pressure, and she did not want that to happen to her. She was also having pain in her back and left arm that morning that she rated at a seven on a pain scale of one to ten. She asked Agency RN #607 if his food was more important than the residents getting their medication, and he stated, yes it was. She told him it was against the law to leave a facility without a nurse, and he stated, I do not know anything about the law. She asked him what would happen if there was an emergency at the facility while he was gone, and he stated that that was what 911 was for. She believed that because she questioned him, he refused to give her medication until approximately 12:30 P.M.</p> <p>Interview on 10/04/24 at 9:55 A.M. with Housekeeping Supervisor #602 revealed she was not at the facility but received a call from Former Housekeeper #604 who was at the facility stating Agency RN #607 left the facility, and there was no nurse in the facility. She contacted ADON/ LPN #601 regarding the concern.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/04/24 at 10:05 A.M. with the Administrator revealed she wanted to clarify her previous statement as she was notified by ADON/ LPN #601 on 09/15/24 that Agency RN #607 left the facility, but she thought ADON/ LPN #601 was at the facility when he left and did not realize that there was not a nurse at the facility while he was gone. She verified she had not completed an SRI and/or investigation regarding the incident stating, I did not know it was an incident as I thought she was in the building until today, 10/04/24. She verified the incident could be considered resident neglect, but she would have to determine through an investigation, which was not completed.</p> <p>Telephone interview on 10/04/24 at 11:06 A.M. with Agency RN #607 revealed he was a travel nurse. He stated 09/15/24 was the only time he worked at the facility. It was very chaotic the whole time he was at the facility due to lack of staff. He stated that in the morning, ADON/ LPN #601 provided him with electronic medical record access but that he could only see what medications the residents were scheduled to get, and he could not sign them off as administered. Agency RN #607 revealed he had checked his blood sugar, and it was low, so he decided to go get some food at a local fast-food restaurant. He did not realize ADON/ LPN #601 had left the facility and/or that he was the only nurse in the facility. He stated he was gone for approximately 20 minutes. When he returned, a few residents (he could not remember their names) were upset that he had left. He stated he just got busy getting back to administering the medications. He verified he had not administered several of the resident's morning medications before he left for lunch. He was unsure of how many residents had not received their morning medications and/or what time he finished the morning medication administration. He was unable to remember the details of Resident #12, who was upset regarding him leaving the facility. He was unable to remember what he said to her and was unable to remember what time he administered her morning medications. He was unable to sign off any of the medications he administered on 09/15/24 as he could not get electronic monitoring access to allow him to. ADON/ LPN #601 told him that she would take care of it.</p> <p>Interview on 10/04/24 at 1:40 P.M. with Ombudsman #610 revealed on 09/19/24 she received a concern from Resident #6 that the only nurse that was scheduled at the facility on 09/15/24 left for lunch leaving the facility without a licensed nurse in the building. She reported Resident #6's concern to the DON on 09/20/24 and did not receive any follow-up as of today, 10/04/24, regarding the concern.</p> <p>Interview on 10/04/24 at 1:51 P.M. with CNA #603 revealed on 09/15/24 at approximately 11:00 A.M., several residents were at the nursing station upset that they had not received their morning medications, and Agency RN #607 had left the facility leaving no nurse in the building. Approximately 45 minutes after Agency RN #607 left, he returned to the facility. Resident #12 was upset because he left, leaving the facility with no nurse, and she had not received her morning medications. Agency RN #607 did not notify her that he was leaving. She noticed both medication carts were unlocked with several residents up at the nursing station close to the medication carts. She received a call from ADON/ LPN #601 and informed her that Agency RN #607 left the facility, and both medication carts were unlocked. ADON/ LPN #601 had her check the top drawer of each cart to see if he had left the keys to try to determine if he left for the remainder of the shift or just for lunch. There were no keys found in the medication carts. Approximately 45 minutes later, Agency RN #607 returned to the facility, and Resident #12 was upset because he left the facility leaving the facility with no nurse and because she had not received her morning medications. CNA #603 stated, the whole situation was kind of scary, especially if there was an emergency.</p> <p>2. Review of Resident #18's medical record revealed an admitted [DATE] with diagnoses including osteomyelitis of vertebra, quadriplegia, and tracheostomy.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of September 2024 MAR revealed Resident #18 received multiple medications on 09/15/24 from 6:00 A.M. to 6:00 P.M. and all were signed off as administered by ADON/LPN #601.</p> <p>Interview on 10/04/24 at 9:19 A.M. with ADON/ LPN #601 verified that Agency RN #607 was unable to sign off any of the medications that he administered and that she had signed them off even though she had not administered them.</p> <p>3. Review of Resident #21's medical record revealed an admitted [DATE] with diagnoses including diabetes, depression, dysphagia, and hemiplegia following a cerebral infarction affecting his right dominant side.</p> <p>Review of September 2024 MAR revealed Resident #21 received multiple medications on 09/15/24 from 6:00 A.M. to 6:00 P.M. and all were signed off as administered by ADON/LPN #601.</p> <p>Interview on 10/04/24 at 9:19 A.M. with ADON/ LPN #601 verified that Agency RN #607 was unable to sign off any of the medications that he administered and that she had signed them off even though she had not administered them.</p> <p>4. Review of Resident #6's medical record revealed an admitted [DATE] with diagnoses including multiple sclerosis, quadriplegia, hypertension, chronic obstructive pulmonary disease, and epilepsy.</p> <p>Review of September 2024 MAR revealed Resident #6 received multiple medications on 09/15/24 from 6:00 A.M. to 6:00 P.M. and all were signed off as administered by ADON/ LPN #601.</p> <p>Interview on 10/04/24 at 9:19 A.M. with ADON/ LPN #601 verified that Agency RN #607 was unable to sign off any of the medications that he administered and that she had signed them off even though she had not administered them.</p> <p>Interview on 10/04/24 at 1:39 P.M. with the Administrator revealed if a nurse was unable to sign off on the electronic medical record, they should sign off on a hard copy of the MAR. The facility had previous internet disruptions, so all the current MARs were printed and in each resident's chart. She verified ADON/ LPN #601 should have directed Agency RN #607 to sign off the medications on the hard copy of the residents' MARs, and she should not have signed off the medications, especially because she did not administer the medications.</p> <p>Interview on 10/04/24 at 3:06 P.M. with the Director of Nursing (DON) revealed an agency nurse received report from the off going nurse, a report sheet that identified key specific items on each resident, an envelope with electronic medical record log in information, and her contact information if they had any questions. She did not have any other specific information that an agency nurse was educated on regarding the nurse's job responsibilities, including not leaving the facility if they were the only nurse in the building.</p> <p>Interview on 10/04/24 at 4:00 P.M. with the Administrator verified she did not have anything specific stating what was given to an agency nurse regarding job responsibilities, including not leaving the facility if they were the only nurse in the building.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Residents #1, #3, #5, #11, and #28 were identified by the Administrator as being cognitively impaired and independently mobile putting them at greater risk of potentially obtaining unsecured medications from the unlocked medication carts.</p> <p>Review of the facility policy labeled, Administering Medications dated April 2019 revealed medications were to be administered in a safe and timely manner as prescribed. The policy revealed medications were administered in accordance with prescriber orders including time frames. Medications were to be administered within one hour of the prescribed time unless otherwise specified. The policy revealed the individual administering the medication initials the resident's MAR after giving each medication and before administering the next resident's medication.</p> <p>Review of the facility policy, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated April 2021 revealed residents have the right to be free from abuse, and neglect. The policy revealed to implement measures to address factors that may lead to abusive situations including preparing staff for caregiving responsibilities. The policy revealed the facility would identify and investigate all possible incidents of abuse, neglect and mistreatment. The facility would investigate and report any allegation within the timeframe required by federal requirement and protect residents from further harm during the investigation.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157987 and Complaint Number OH00157157.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on interview, record review, and review of the facility policy, the facility failed to ensure Resident #12 was free of significant medication error. This affected one resident (#12) out of five residents reviewed for significant medication error. The facility census was 32.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #12 revealed an admitted [DATE] and diagnoses included acute respiratory failure with hypoxia, hypertension, diabetes and low back pain. Review of Self-Medication assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #611 revealed Resident #12 did not want to self-administer her medication. All medication would be provided by nursing.</p> <p>Review of the care plan dated 08/21/23 revealed Resident #12 had hypertension. Interventions included giving anti-hypertension medications as ordered and monitoring, documenting, and reporting any signs of hypertension including headache, visual problems, confusion, lethargy, nausea and/or difficulty breathing.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #12 had intact cognition. She received scheduled pain medications to control her pain.</p> <p>Review of the care plan dated 08/23/24 revealed Resident #12 had actual pain related to arthritis, right foot neuropathy, back pain, and shoulder pain. Interventions included administering medications as ordered, evaluating effectiveness of pain interventions, and monitoring, recording, and reporting to the nurse any signs of pain.</p> <p>Review of the September 2024 physician's orders and September 2024 Medication Administration Record (MAR) revealed Resident #12 was to receive the following medication at 8:00 A.M.: buspirone 15 milligram (mg) by mouth twice a day every morning and bedtime for anxiety. She was to receive the following medications at 9:00 A.M. that included: Cozaar 100 mg tablet by mouth once a day for high blood pressure, Lidocaine patch five percent topically to lower back due to pain, Pristiq extended release 100 mg by mouth once a day for depression, and carvedilol 6.25 mg by mouth two times a day for high blood pressure with a meal. All of resident #12's medications scheduled for 09/15/24 from 8:00 A.M. to 6:00 P.M. were signed off as administered by Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #601 who was not working on 09/15/24.</p> <p>Interview on 10/04/24 at 8:53 A.M. with Resident #6 revealed on 09/15/24 approximately at 11:30 A.M. Agency RN #607 left the facility and went to lunch resulting in no nurse in the facility. Resident #6 revealed she proceeded to go outside and observed Agency RN #607 return to the facility approximately 45 minutes later carrying a Burger King bag and drink. On his return, Resident #12 had questioned Agency RN #607 as to why he had left and what if something had happened while he was gone. She revealed Agency RN #607 had responded by stating, there was 911 which she felt was inconsiderate and rude. She revealed Resident #12 had been upset as she had not received her morning medications despite, he left for lunch. She revealed Agency RN #607 continued to not give Resident #12 her medications even after his return.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/04/24 at 9:19 A.M. with ADON/LPN #601 revealed she was at the facility on 09/15/24 at approximately 6:30 A.M. to provide Agency RN #607 with the layout of the building and his electronic medical record access because this was his first time at the facility. Certified Nursing Assistant (CNA) #603 stated that some of the residents were upset that Agency RN #607 left for lunch and they had not received their morning medications. Agency RN #607 was unable to sign off any of the medications that he administered and that she had signed them off even though she had not administered them.</p> <p>Interview on 10/04/24 at 9:37 A.M. with Resident #12 revealed on 09/15/24 at approximately 11:00 A.M. she had not received her morning medications (due at 8:00 A.M. and 9:00 A.M.) and went to the nursing station to see why she had not received them. Former Housekeeper #604 told her that Agency RN #607 left the facility, and there was no nurse on duty. She said she waited from 11:00 A.M. to 11:45 A.M. until he returned to the facility carrying a fast-food bag and a drink. She said she was upset that she had not received her morning medications, which included pain medication and medications for her blood pressure, and it was inappropriate for him to leave the facility with no nurse to go out for fast-food. She revealed she was to take blood pressure medication and was concerned that she had not received her medication because her mother had a massive stroke due to high blood pressure, and she did not want that to happen to her. She was also having pain in her back and left arm that morning that she rated at a seven on a pain scale of one to ten. She asked Agency RN #607 if his food was more important than the residents getting their medication, and he stated, yes it was. She told him it was against the law to leave a facility without a nurse, and he stated, I do not know anything about the law. She asked him what would happen if there was an emergency at the facility while he was gone, and he stated that that was what 911 was for. She believed that because she questioned him, he refused to give her medication until approximately 12:30 P.M.</p> <p>Telephone interview on 10/04/24 at 11:06 A.M. with Agency RN #607 revealed he was a travel nurse. He stated 09/15/24 was the only time he worked at the facility. It was very chaotic the whole time he was at the facility due to lack of staff. He stated that in the morning, ADON/ LPN #601 provided him with electronic medical record access but that he could only see what medications the residents were scheduled to get, and he could not sign them off as administered. Agency RN #607 revealed he had checked his blood sugar, and it was low, so he decided to go get some food at a local fast-food restaurant. He did not realize ADON/ LPN #601 had left the facility and/or that he was the only nurse in the facility. He stated he was gone for approximately 20 minutes. When he returned, a few residents (he could not remember their names) were upset that he had left. He stated he just got busy getting back to administering the medications. He verified he had not administered several of the resident's morning medications before he left for lunch. He was unsure of how many residents had not received their morning medications and/or what time he finished the morning medication administration. He was unable to remember the details of Resident #12, who was upset regarding him leaving the facility. He was unable to remember what he said to her and was unable to remember what time he administered her morning medications. He was unable to sign off any of the medications he administered on 09/15/24 as he could not get electronic monitoring access to allow him to. ADON/ LPN #601 told him that she would take care of it.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/04/24 at 1:39 P.M. with the Administrator revealed if a nurse was unable to sign off on the electronic medical record, they should sign off on a hard copy of the MAR. The facility had previous internet disruptions, so all the current MARs were printed and in each resident's chart. She verified ADON/ LPN #601 should have directed Agency RN #607 to sign off the medications on the hard copy of the residents' MARs, and she should not have signed off the medications, especially because she did not administer the medications. Since ADON/ LPN #601 signed off all the medications, she had no documented evidence of the exact time Resident #12 received her morning medications on 09/15/24.</p> <p>Interview on 10/04/24 at 1:51 P.M. with CNA #603 revealed on 09/15/24 at approximately 11:00 A.M., several residents were at the nursing station upset that they had not received their morning medications, and Agency RN #607 had left the facility leaving no nurse in the building. Approximately 45 minutes after Agency RN #607 left, he returned to the facility. Resident #12 was upset because he left, leaving the facility with no nurse, and she had not received her morning medications.</p> <p>Review of the facility policy labeled, Administering Medications dated April 2019 revealed medications were to be administered in a safe and timely manner as prescribed. The policy revealed medications were administered in accordance with prescriber orders including time frames. Medications were to be administered within one hour of the prescribed time unless otherwise specified. The policy revealed the individual administering the medication initials the resident's MAR after giving each medication and before administering the next resident's medication.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157987.</p>		

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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)
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>39973</p> <p>Based on record review, interview, and review of the facility policy, the facility failed to ensure the required members, including the Director of Nursing (DON), attended the Quality Assurance and Performance Improvement (QAPI) meetings at least quarterly. This had the potential to affect all 32 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the attendance sheets for the QAPI meetings from 10/15/23 to 09/11/24 revealed the facility met monthly; however, on 02/14/24, 03/18/24, 04/25/24, 05/11/24, 06/13/24, and 07/22/22/24 the DON was not present at the meetings.</p> <p>Interview on 10/11/24 at 12:00 P.M. with [NAME] President of Operations (VPO) #615 and the Administrator verified the DON failed to attend QAPI meetings from February through July 2024. They were unable to say why she had not attended.</p> <p>Review of the facility policy labeled, Quality Assurance and Performance Improvement (QAPI) Program dated February 2020 revealed the facility shall develop, implement and maintain ongoing, facility-wide, data driven QAPI program that was focused on indicators of the outcome of care and quality of life of the residents. The administrator was responsible for assuring that the facilities QAPI program complied with federal, state, and local regulatory agency requirements. The committee meets monthly to review reports, evaluate data, and monitor QAPI related activities and adjust the plan. The policy did not include which members were required to attend the QAPI meetings.</p> <p>This deficiency represents non-compliance identified during the complaint investigation.</p>