STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365268	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Wadsworth	147 Garfield St Wadsworth, OH 44281

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on observation, interview and review of facility policy, the facility failed to ensure insulin pens were dated and labeled after opening. This affected three residents (#9, #16, and #40) of four residents observed for insulin pens during medication administration. The facility census was 66. Findings include: 1. Review of Resident #9's medical records revealed an admitted [DATE] with diagnoses including but not limited to diabetes. Review of Resident #9's physician order for March 2025 revealed resident was ordered Glargine insulin (long-acting insulin) 25 units subcutaneous (SQ) twice a day (BID). Observation during medication administration on 03/13/25 at 8:22 A.M. of the insulin pens with Licensed Practical Nurse (LPN) 154 revealed multiple insulin pens were not dated when opened with expiration date. Resident #9's Glargine insulin pen had no date to indicate when it was opened. Interview on 03/13/25 at 9:03 A.M. with LPN #154 confirmed Resident #9's insulin pen was not dated when opened. LPN #154 reported the insulin pen should be dated when opened and stated she was unsure how long insulin pens were good for after opening. Interview on 03/13/25 at 9:10 A.M. with Director of Nursing (DON) confirmed insulin pens are to be dated when opened. DON confirmed there was no date on the Glargine insulin pen for Resident #9. 2. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including but not limited to diabetes. Review of Resident #16's physician order for March 2025 revealed an order for Basaglar Kwikpen (Glargine insulin, long-acting insulin) give 12 units SQ once a day (QD). Observation during medication administration on 03/13/25 at 8:22 A.M. of the insulin pens with LPN #154 revealed multiple insulin pens were not dated when opened with expiration date. Resident #16's Basaglar KwikPen, (Glargine insulin) had no date to indicate when it was opened. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/13/25 at 9:03 A.M. with LPN #154 confirmed Resident #16's insulin pen was not dated when opened. LPN #154 reported the insulin pen should be dated when opened and stated she was unsure how long insulin pens were good for after opening. Interview on 03/13/25 at 9:10 A.M. with DON confirmed insulin pens are to be dated when opened. DON confirmed there was no date on the Glargine insulin pen for Resident #16. 3. Review of the medical record for Resident #40 revealed an admitted [DATE] with diagnoses including but not limited to diabetes. Review of Resident #40's physician order for March 2025 revealed an order for Fiasp (aspart insulin), (rapid acting insulin) 100 unit/ml, give 6 units sq with meals. Observation during medication administration on 03/13/25 at 8:22 A.M. of the insulin pens with LPN #154 revealed multiple insulin pens were not dated when opened with expiration date. Resident #40's Fiasp (aspart insulin), (rapid acting insulin) 100 unit/ml, give 6 units sq with meals had no date to indicate when it was opened. Interview on 03/13/25 at 9:03 A.M. with LPN #154 confirmed Resident #40'S insulin pen was not dated when opened. LPN #154 reported the insulin pen should be dated when opened and stated she was unsure how long insulin pens were good for after opening. Interview on 03/13/25 at 9:10 A.M. with DON confirmed insulin pens are to be dated when opened. DON confirmed there was no date on the Fiasp insulin pen for Resident #40. Review of facility policy, Medication Storage in the Facility, dated May 2020, revealed mediations are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. Furthermore, all medications dispensed by the pharmacy are stored in the container with the pharmacy label and blood sugar solutions once opened, require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on observation, interview and record review the facility failed to maintain infection control procedures while administering medications. This affected two residents (#46 and #49) of four residents observed for infection control during medication administration. The facility census was 66. Findings include: 1. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnosis including but not limited to scoliosis, stage three chronic kidney disease, and hypertension. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had intact cognition. Review of physician orders for March 2025 revealed resident #49 was ordered, Gabapentin 100 milligram (MG) one capsule three times a day (TID) for pain, Metoprolol Succinate Extended Release (ER) 50 mg one tablet once a day (QD) for blood pressure, and Pantoprazole 40 mg one tablet qd for acid reflux. Observation of medication administration on 03/13/25 at 7:27 A.M. with Licensed Practical Nurse (LPN) #122 for Resident #49, revealed three medications to include Gabapentin 100 milligram mg one capsule, Metoprolol Succinate ER 50 mg one tablet, and Pantoprazole 40 mg one tablet were all placed in a medicine cup. LPN #122 handed the medicine cup to Resident #49 who took two of the pills but dropped one pill onto her comforter on her bed. LPN #122 was moving the comforter around to locate the pill and then told Resident #49 to take the pill. Resident #49 picked the pill up off her comforter and ingested it. Interview on 03/13/25 at 7:33 A.M. with LPN #122 confirmed she should have discarded the medication that fell on Resident #49's comforter. Interview on 03/13/25 at 9:10 A.M. with Director of Nursing (DON) confirmed when a medication is dropped on the Resident #49's comforter or bed should be discarded due to infection control concerns. 2. Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnosis including but not limited to type two diabetes mellitus (DM) with diabetic nephropathy, chronic kidney disease and with polyneuropathy, and stage three chronic kidney disease. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 had intact cognition. Review of physician orders for March 2025 revealed resident #49 was ordered Lexapro 10 mg to give 15 mg qd. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/13/25 at 8:22 A.M. during medication pass revealed LPN #154 take the medication package for Lexapro 10 mg and pop the one and a 1/2 pill from it. The whole pill of Lexapro fell on to the medication cart. LPN #154 picked up the pill with her bare hands and placed it in the medicine cup with all the other pills she had already placed in the medicine cup. LPN #154 proceeded to take the medicine cup into Resident #46's room. LPN #154 handed the medicine cup to Resident #46 who ingested the pills. During medication administration LPN #154 took the glucometer into Resident #46's room and placed it on the over the bed tray with no barrier or disinfecting first. Interview on 03/13/25 at 9:03 A.M. with LPN #154 confirmed she should have discarded the Lexapro medication that fell on the medication cart and not used her bare hands to pick it up and place in the medicine cup. LPN #154 confirmed she should have placed a barrier under the glucometer or disinfected the over the bed tray. Interview on 03/13/25 at 9:10 A.M. with DON confirmed when medication is dropped it is to be discarded, and glucometers required a barrier or disinfect the over the bed tray. Review of the facility policy, Fingerstick Glucose Level, revised 11/2019, revealed policy to obtain blood sample to determine resident's blood glucose level and to prepare a clean field on the bedside stand or overbed table. Review of facility policy, Injectable Medication Administration, revised January 2018, revealed administer medications via subcutaneous route in a safe, accurate and effective manner and use a barrier if supplies or medication will be set down in a resident's room.