STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365300	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Post-Acute Rehab Center	1463 Tallmadge Road Kent, OH 44240

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to timely notify the physician of a significant change in condition and failed to notify the physician when nursing staff independently held physician ordered medications. This affected one resident (#169) of three residents reviewed for notification of change. Findings include:Review of the closed medical record for Resident #169 revealed an admission date of 12/11/25 and a discharge date [DATE]. Diagnoses included hypervolemia (fluid overload), orthostatic hypotension, hypertension, dehydration, acute kidney failure, type II diabetes, anxiety, and depressionReview of Resident #169's physician's orders dated 12/11/25 revealed the resident had an order for Humulin, an intermediate acting insulin lasting 12 to 24 hours, to inject eight units subcutaneously at 8:00 A.M. and 4:30 P.M. In addition, an order to check her blood sugar, before meals and at bedtime; 7:30 A.M., 11:30 A.M., 5:30 P.M., 8:00 P.M. Additional notes stated to notify the physician for blood glucose levels over 400 or under 70. Morning medication included: Tylenol (analgesic) 1000 milligram (mg), Atorvastatin (lowers cholesterol) 20 mg, vitamin D3 (supplement) 20 microgram (mcg), vitamin B (supplement) 12 mcg, vitamin D2 (supplement) 1250 mg, levothyroxine (thyroid hormone) 50 mg, losartan (medication to treat high blood pressure and protect kidneys in type II diabetics) 50 mg, Protonix (stomach acid reducer) 40 mg, Lyrica (anticonvulsant and nerve pain medication) 150 mg used for nerve pain, Buspar (antianxiety) 5 mg used to treat anxiety.Review of the December 2025 Medication Administration Record (MAR) on 12/18/25 revealed the Tylenol, Atorvastatin, vitamin D3, vitamin B12, and vitamin D2 were signed off as administered, BuSpar and vitamin D2 were not signed off as administered. The resident's blood sugar result at 7:30 A.M. was 240 and 182 at 11:30 A.M. Humulin was not administered at 8:00 A.M. as ordered. Review of the nurse's progress notes dated 12/18/25 at 8:54 A.M. revealed the nurse was given report from the night shift nurse that Resident #169 was lethargic, breathing heavily, and slow to respond to voice command. Both nurses observed Resident #169 lethargic, breathing and slow to respond to stimuli. During morning medication administration, the nurse noted the resident was breathing heavily, lethargic and slow to respond to voice. The physician was called, and the nurse was waiting for response. There was no documentation that the resident's physician ordered medications, including insulin (blood glucose at 7:30 A.M. was 240) were held.Progress noted dated 12/18/25 at 11:59 A.M. stated Resident #169 was unresponsive. Blood pressure was 70/30, blood glucose level was 182, and respirations were 30 per minute. Resident #169 stirred in response to a sternal rub. The physician was called at this time. There was no return call at this time. Emergency Medical Service (EMS) was called, and Resident #169 wat transferred to the hospital.Interview with the Medical Director (MD) on 03/11/26 at 3:29 P.M. stated he was not informed that the medications were held on the morning 12/18/25 and did not recall speaking to the nurse to give orders to hold Resident #169 medication, including insulin with a blood sugar of 240. The MD stated he would only hold fast acting insulin not long-acting insulin. Interview on 03/11/26 at 4:24 P.M. with Certified Medication Aid (CMA) #600 stated Resident #169 was sleepy due to a new medication (Buspar). On 12/18/25 she was instructed by Licensed Practical Nurse (LPN) #516 to hold insulin if the resident (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not eat her breakfast. CMA #600 stated Resident #169 was not awake that morning.Interview on 03/11/25 at 4:31 P.M. with LPN #516 stated in morning shift report, the night nurse informed her that Resident #169 was not doing well and was not eating. LPN #516 wanted to send Resident #169 to the emergency room (ER) immediately but was told by the night nurse and the Director of Nursing (DON) to continue to monitor the resident. LPN #516 instructed CMA #600 to hold the insulin if the resident did not eat her breakfast per nursing judgement. LPN #516 sent a message to the physician; however, there was no response. LPN #516 stated Resident #169 did not look well and was sent to the ER.Interview on 03/13/26 at 9:30 A.M. with the DON stated the nurse called the physician on 12/18/25 and waited for a call back with instructions. CMA #600 held morning medications including insulin per nursing judgement on 12/18/25. Review of the facility policy titled Preparation and General Guidelines, dated May 2020, stated if a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time an explanatory note is entered on the record. If a dose of vital medication is withheld, refused, or not available, the prescriber is notified unless otherwise instructed by the prescriber.Review of the policy titled Change in the Residents Condition or Status, dated 05/01/2025, stated nurses will immediately notify the resident: consult with resident's attending physician, nurse practitioner, physician assistant or clinical nurse specialist and notify the resident representative of a significant change in the resident deterioration in health in a life-threatening condition.This deficiency was an incidental finding identified during the complaint investigation.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the emergency transport report, review of hospital records, interview and facility policy review, the facility failed to ensure Resident #169's insulin was administered as prescribed and failed to ensure timely transfer to the emergency room when a significant change in condition was identified. This affected one (Resident #169) of three residents reviewed for medication administration. The facility census was 66.Findings include:Review of the closed medical record for Resident #169 revealed an admission date of [DATE] and a discharge date [DATE]. Diagnoses included hypervolemia (fluid overload), orthostatic hypotension, hypertension, dehydration, acute kidney failure, type II diabetes, anxiety, and depressionReview of Resident #169's physician's orders dated [DATE] revealed the resident had an order for Humulin, an intermediate acting insulin lasting 12 to 24 hours, to inject eight units subcutaneously at 8:00 A.M. and 4:30 P.M. In addition, an order to check her blood sugar, before meals and at bedtime; 7:30 A.M., 11:30 A.M., 5:30 P.M., 8:00 P.M. Additional notes stated to notify the physician for blood glucose levels over 400 or under 70. Review of the [DATE] Medication Administration Record on [DATE] revealed Resident #169's blood sugar result at 7:30 A.M. was 240 and 182 at 11:30 A.M. Humulin insulin was not administered between 7:00 A.M. to 11:00 A.M. as ordered by the physician.Review of the nurse's progress notes dated [DATE] at 8:54 A.M. revealed the nurse was given report from the night shift nurse that Resident #169 was lethargic, breathing heavily, and slow to respond to voice command. Both nurses observed Resident #169 lethargic, breathing and slow to respond to stimuli. During morning medication administration, the nurse noted the resident was breathing heavily, lethargic and slow to respond to voice. The physician was called, and the nurse was waiting for response. There was no documentation that the resident's physician ordered medications, including insulin (blood glucose at 7:30 A.M. was 240) were held.Progress noted dated [DATE] at 11:59 A.M. stated Resident #169 was unresponsive. Blood pressure was 70/30, blood glucose level was 182, and respirations were 30 per minute. Resident #169 stirred in response to a sternal rub. The physician was called at this time. There was no return call at this time. emergency medical service (EMS) was called, and Resident #169 wat transferred to the hospital.Review of the emergency transport report dated [DATE] revealed EMS was called at 11:31 A.M., arrived on scene at 11:32 A.M., transferred to the emergency room at 11:45 A.M. and arrived at the emergency room at 11:57 A.M. The resident was unresponsive and hyperglycemic with a blood glucose level too high to register on the glucometer (over 600). (The significant change in condition began on night shift).Review of the hospital records dated [DATE] revealed Resident's glucose in the emergency room was 951, and she was admitted with diagnoses including diabetic ketoacidosis, septic shock, altered mental status, and hypotension. The resident expired in the hospital on [DATE].Interview with the Medical Director (MD) on [DATE] at 3:29 P.M. stated he was not informed that the medications were held on the morning [DATE] and did not recall speaking to the nurse to give orders to hold Resident #169's medication. The MD stated he would only hold fast acting insulin not long-acting insulin. Interview on [DATE] at 4:24 P.M. with Certified Medication Aid (CMA) # 600 stated Resident #169 was sleepy due to a new medication. On [DATE] she was instructed by Licensed Practical Nurse (LPN) #516 to hold insulin if the resident did not eat her breakfast. CMA #600 stated Resident #169 was not awake that morning.Interview on [DATE] at 4:31 P.M. with LPN #516 stated she received in morning shift report from the night nurse that resident was not doing well and was not eating. LPN #516 wanted to send Resident #169 to the emergency room immediately but was told by the night nurse and the Director of Nursing (DON) to continue to monitor. LPN #516 instructed CMA #600 to hold the insulin if the resident did not eat her breakfast per nursing judgement. LPN #516 sent a message to the physician; however, there was no response. LPN #516 stated Resident #169 did not look well and was sent to the emergency room.Interview on [DATE] at 9:30 A.M. with the DON stated the nurse called the physician on [DATE] and waited for a call back (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with instructions. CMA #600 held morning medications including insulin per nursing judgement on [DATE]. Review of the facility policy titled Preparation and General Guidelines, dated [DATE], stated If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time an explanatory note is entered on the record. If a dose of vital medication is withheld, refused, or not available, the prescriber is notified unless otherwise instructed by the prescriber.This deficiency represents non-compliance investigated under Master Complaint Number 2713937.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, review of manufacture's guidelines and facility policy review, the facility failed to ensure a medication error rate of less than 5%. Four errors were observed in 34 opportunities resulting in a 11.76% medication error rate. This affected one (Resident #114) of four residents observed for medication administration. The facility census was 66.Findings include:Review of the medical record for Resident #114 revealed an admission date 02/24/26 with diagnoses including respiratory failure, malnutrition, embolism of right upper extremity and bilateral lower extremities, anemia and hypotension.Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #114 had moderate cognitive impairment and required substantial assistance with activities of daily living.Review of the physician orders for March 2026 revealed orders for Brinzolamide ophthalmic drops 1% (reduces high pressure in the eye) one drop twice a day. The order did not clarify if the drop were to be instilled in right eye, left eye or both. Brimonidine 0.2% ophthalmic drop (reduces high pressure in the eye) to be administered one drop in each eye twice a day. Atropine 1% ophthalmic drop (used to dilate pupils) to be administered one drop in right eye. Prednisolone Acetate 1% ophthalmic drop (corticosteroid) to be administered in the right eye once daily.Observation of medication administration on 03/12/26 at 8:56 A.M. with Licensed Practical Nurse (LPN) #593 revealed she prepared Residents #114's morning medication including Brinzolamide, Brimonidine, Atropine, and Prednisolone eye drops. LPN #114 at 9:12 A.M. administered Atropine in both eyes, at 9:14 A.M. administered Prednisolone in both eyes, at 9:15 A.M. administered Brimonidine in both eyes, at 9:17 A.M. administered Brinzolamide in both eyes.Interview with LPN #593 stated the facility policy for administering eye drops is to wait five minutes before administering another eye drop. LPN #593 verified she did not wait five minutes between administering eye drops. LPN #593 verified she administered Atropine, Prednisolone and Brinzolamide in both eyes because the resident requested the drops in both eyes. LPN #593 verified the Brinzolamide order did not identify what eye to instill the drops, and the order was not clarified with the physician.Review of the manufactures instruction for Atropine Ophthalmic stated if you are to use more than one drop in the same eye, wait at least five minutes before instilling the next drop.Review of the manufacturer's instructions for Brimonidine stated if more than one topical ophthalmic product is being used, the products should be administered at least five minutes.Review of manufacturer's instructions for Prednisolone stated if you are to use more than one drop in the same eye, wait at least five minutes before instilling the next drop.Review of the manufacturer's instructions for Brinzolamide stated if you are using another medication in the eye, use it 10 minutes before or 10 minutes after you use Brinzolamide eye drops.Review of the facility policy titled Preparation and General Guidelines, dated May 2020, stated medications are administered in accordance with orders of the prescriber. If a dose seems excessive considering the resident condition or a medication order seems to be unrelated to current diagnoses or conditions, the nurse calls the pharmacy for clarification prior to the administration of the medication or contacts the prescriber for clarification.Review of the facility policy titled Specific medication administration procedures, dated May 2020, stated if another drop of the same or different mediation is prescribed for administration in the same eye at the same time, wait five minutes or the specified length of time recommended per manufacture's instruction or pharmacy labeling.This deficiency represents non-compliance investigated under Master Complaint Number 2713937.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and facility policy review, the facility failed to ensure a complete and accurate medical record for Resident #169. This affected one (Resident #169) out of nine residents' records reviewed during a complaint investigation. The facility's census was 66.Findings include:A review of Resident #169's medical record revealed an admission date of 12/11/25 with diagnoses including type II diabetes mellitus with hyperglycemia, cognitive communication deficit, orthostatic hypotension, dehydration, depression, generalized anxiety disorder and acute kidney failure.A review of Resident #169's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident required partial to moderate assistance with bathing and with personal hygiene. A physical therapy note dated 12/17/25 revealed the resident required maximum assistance with sit-to-stand transfers and stand-by assistance with bed mobility. A Basic Interview for Mental Status (BIMS) was not conducted, but documentation throughout the chart revealed the resident was alert and oriented to person and place.Further review of Resident #169's medical record revealed a physician's order for Humulin N NPH Insulin (a crucial hormone that regulates blood sugar levels and plays a vital role in energy metabolism) KwikPen 100 units per milliliter (mL) (3 mL) 8 units; subcutaneous (beneath the skin) twice a day at 8:00 A.M. and 4:30 P.M. Further review of the medical record revealed an additional order for insulin Aspart U-100; 100 unit/mL (3 mL); 5 units; subcutaneous twice a day to be administered between 7:00 A.M. - 11:00 A.M. and 4:30 P.M. - 6:30 P.M.Further review of Resident #169's medical record revealed a nurse's progress note from 12/18/25 at 8:54 A.M. and authored by Licensed Practical Nurse (LPN) #516 stating this nurse was given report from the night shift nurse that the resident was lethargic, breathing heavily, slow in arousing to voice commands. This nurse and the night shift nurse walked up to the resident's room, this nurse observed the resident in with bed labored breathing and slowly responding to stimuli. During morning medication pass, this nurse noted resident breathing heavily, lethargic, slowly responding to voice commands, and vitals within normal limits (WNL). The physician was called, waiting for advice. The resident's daughter was updated about the resident's condition. The plan of care was ongoing.A review of Resident #169's Medication Administration Record (MAR) for December 2025 revealed she did not receive her insulin on 12/18/25.Further review of Resident #169's physician's orders revealed no order to hold her insulin.An interview with Medication Aide #600 on 03/11/26 at 4:24 P.M. revealed Resident #169 was sleepy on the morning of 12/18/25 due to a new medication (Buspar, and antianxiety medication). She was told by LPN #516 to hold the resident's insulin if the resident didn't eat breakfast. She stated Resident #169 did not eat breakfast, so the insulin was not given per LPN #516's instructions.An interview with LPN #516 on 03/11/25 4:31 P.M. revealed she received report on 12/18/25 at 7:00 A.M. from the overnight nurse that Resident #168 wasn't doing well and wasn't eating. LPN #516 further stated she instructed Medication Aide #600 to hold the resident's insulin if the resident didn't eat her breakfast per nursing judgement. LPN #516 further stated her progress note should contain information regarding her decision to hold Resident #169's insulin and her rationale for her decision. LPN #516 also stated the resident's vital signs should be in the medical record or in her progress note, not just stating vital signs were WNL.An interview with the Director of Nursing (DON) on 03/12/26 at 9:20 A.M. verified no notes or documentation about the nurse's decision to hold medications or a rationale behind that decision were present in Resident #169's medical record. The interview with the DON further verified the lack of vital signs in the medical record or the nurses' notes on 12/18/25. The DON further verified no order to withhold insulin was ever received from the physician, and no such order was present in Resident #169's medical record.Review of the facility's policy titled Change in the Residents Condition or Status, updated 05/01/25, revealed the nurse will record in the resident's medical record information relative to changes in the resident's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical/mental condition or status (e.g. assessment, appropriate notifications, interventions, and response).This deficiency is an incidental finding identified during the complaint investigation.