STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365402	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Alliance Ctr for Rehab & NC Inc	11750 Klinger Avenue NE Alliance, OH 44601

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on interview and record review, the facility failed to ensure resident funds were disbursed to the resident's estate within 30 days as required. This affected one (Resident #79) of six residents reviewed for personal funds. The facility census was 73. Findings include: Review of Resident #79's medical record revealed an admitted [DATE] and diagnoses including dysphagia, weakness, cerebral infarction, dementia without behavioral disturbance and anemia. Resident #79's son was listed as his emergency contact. Resident #79 expired in the facility on [DATE]. Review of the facility resident funds report dated [DATE] revealed Resident #79 had a balance of $92.51. There was a notation that Resident #79 had expired on [DATE] on the report. Review of Resident #79's resident fund statement for [DATE] through [DATE] revealed Resident #79 had an ending balance of $92.51 as of [DATE]. Interview on [DATE] at 4:19 P.M. with Lead Receptionist (LR) #875 revealed the facility's corporate office was responsible for disbursing an expired or discharged resident's funds to their estate or other designated location. LR #875 stated she could not complete that part of the resident funds process and confirmed Resident #79's funds had not been disbursed to his estate as of the time of the interview. Follow-up interview on [DATE] at 4:54 P.M. with Registered Nurse (RN)/ Regional #802 verified Resident #79's funds were not disbursed within 30 days of his death as required and shared there was not a facility policy specific to resident funds.

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	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** 46195 Based on interview, record review, and facility policy, the facility failed to ensure the physician and/or nurse practitioner and family of Resident #78 were notified of a change in condition. This affected one resident (#78) out of 20 residents reviewed for notification of change in condition. The facility census was 73. Findings include: Review of closed medical record for Resident #78 revealed an admitted [DATE] and an expiration date of 02/17/25. Diagnoses included cognitive communication deficit, chronic obstructive pulmonary disease (COPD), complete traumatic amputation of one right lesser toe, essential hypertension (high blood pressure), and dementia. Review of the baseline care plan located in the facility document Clinical Admission Documentation 0419-U, dated 02/07/25, revealed Resident #78 had respiratory issues due to history of smoking, pulmonary effusion (collection of fluid around the lungs), and need for oxygen. Approaches included keep head of bed up as tolerated, check pulse oxygen level per order, provide oxygen therapy per order, routine monitoring and note resident compliance, provide medications per order, report any wheezing, shortness of breath, rales (crackles)/rhonchi (low pitched sound that resembles snoring and indicates blockage in the airways) with breath sound checks to physician or nurse practitioner. Further review of medical record revealed from 02/08/25 until 02/16/25 Resident #78's oxygen saturation readings were between 90 and 95 percent. On 02/17/25, at 8:33 A.M., it was recorded by Licensed Practical Nurse (LPN) #895 Resident #78's oxygen saturation level had dropped to 78 percent and at 10:13 A.M. Resident #78's oxygen saturation level was 78 percent. On 02/17/25 at 8:23 P.M. it was documented by LPN #932 Resident #78's oxygen saturation level was 79 percent and at 8:37 P.M. the oxygen saturation level remained low at 79 percent. There was nothing documented in the progress notes indicating the physician/nurse practitioner or the family was notified of the low oxygen saturation levels on 02/17/25. Interview on 04/02/25 at 2:16 P.M. with Nurse Practitioner (NP) #933 revealed she could not recall having a conversation with the facility regarding Resident #78 having low oxygen levels. NP #933 stated Resident #78 was a pretty sick lady. NP #933 said if she had been notified and if the family wanted additional medical intervention, she would have ordered the resident to be sent to the hospital. Interview on 04/03/25 at 11:53 A.M. with the Power of Attorney for Resident #78 revealed the facility had never told him Resident #78's oxygen levels were declining on 02/17/25. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 04/02/25 at 1:53 P.M. and on 04/03/25 at 8:47 A.M. with the Director of Nursing (DON) revealed if she had been taking care of Resident #78, she would have notified the physician and/or the nurse practitioner and family when the resident's oxygen levels had fallen below 88 percent. The DON stated when a nurse practitioner was notified, there should be a progress note in the medical record. The DON confirmed there was no documentation in the medical record that the nurse practitioner/physician or family had been notified of Resident #78's low oxygen levels on 02/17/25. Review of the undated facility policy Change in Residents Condition or Status revealed the nurse would immediately consult with the resident's attending physician or on-call physician and notify the resident's authorized representative when there was a significant change in the resident's physical, mental, or psychosocial status, which included a deterioration in health, mental, or psychosocial status. The nurse would record in the resident's medical record information relative to changes in the medical/mental condition or status which included assessment, appropriate notifications, interventions, and response.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, record review, interview, facility policy review, and review of the National Institute of Health guidance, the facility failed to ensure reusable resident nebulizer masks were bagged to prevent the potential for cross contamination of the nebulizer mask. This affected two (Residents #3 and #46) of three residents (Residents #3, #17 and #46) reviewed for respiratory therapy. The facility census was 73. Findings include: 1. Review of Resident #3's medical record revealed the resident was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), acute on chronic diastolic congestive heart failure (CHF) and chronic respiratory failure with hypoxia (insufficient oxygen supply at the tissue level). Review of Resident #3's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and had no rejection of care. Review of physician orders revealed an order dated 08/25/24 for albuterol sulfate solution (bronchodilator that works by relaxing and opening the airways of the lungs) for nebulization (a process where liquid medication is converted into a fine mist and inhaled allowing for direct delivery of medications to the lungs and airways), 5 milligrams (mg)/milliliter (ml), one bullet inhalation every two hours as needed for shortness of breath. Observation on 03/31/25 at 3:33 P.M. revealed Resident #3's nebulizer mask was sitting on top of the resident's continuous positive airway pressure (CPAP) machine on the bedside table. Interview on 03/31/25 at 3:43 P.M. with Licensed Practical Nurse (LPN) #861 confirmed Resident #3's nebulizer mask was uncovered and should be covered when not in use to prevent cross contamination of the nebulizer mask. Observation on 04/03/25 at 6:57 A.M. revealed Resident #3's nebulizer mask was sitting on top of the nebulizer machine uncovered with an empty plastic bag sitting next to it on the bedside table. Interview on 04/03/25 at 7:00 A.M. with Certified Nursing Assistant (CNA) #815 confirmed Resident #3's nebulizer mask was uncovered and should be covered when not in use to prevent cross contamination of the nebulizer mask. 2. Review of Resident #46's medical record revealed the resident was readmitted on [DATE] with diagnoses including chronic respiratory failure, major depressive disorder and Alzheimer's disease. Review of Resident #46's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #46's physician orders revealed an order dated 11/21/23 for ipratropium-albuterol solution (used for treatment or prevention of tightening of muscles that line the airway), 0.5 mg-3 ml one unit dose inhalation four times a day. Observation on 03/31/25 at 3:30 P.M. revealed Resident #46's nebulizer mask was uncovered and sitting on top of a baseball cap on the bedside table. Interview on 03/31/25 at 3:42 P.M. with LPN #861 confirmed Resident #46's nebulizer mask was uncovered and should have been covered when not in use to prevent cross contamination of the nebulizer mask. Review of facility policy Specific Medication Administration Procedures, dated May 2009, revealed after the administration of medications through a small volume nebulizer was completed, the parts should be dissembled, cleaned, and stored in a clean plastic bag with the resident's name and date. Review of the National Institute of Health guidance for cleaning and storage of nebulizer parts between uses, dated October 2021, revealed Store nebulizer parts in a dry, clean plastic storage bag. If the nebulizer is used by more than one person, keep each person's medicine cup, mouthpiece or mask, and tubing in a separate, labeled bag to prevent the spread of germs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review and interview, the facility failed to ensure an accurate accounting and administration of opioid medications. This affected two (Residents #25 and #58) of two residents identified during review of a Self-Reported Incident (SRI) investigation. Findings include: Review of Resident #25's medical record revealed the resident was admitted on [DATE] with diagnoses including bilateral primary osteoarthritis of the knee, other chronic pain and depression. Review of Resident #25's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #25's physician orders revealed an order dated 02/10/25 for oxycodone 10 mg (milligrams) three times a day to be administered at 9:00 A.M., 1:00 P.M. and 6:30 P.M. Review of SRI Tracking Number #258409 dated 03/19/25 revealed there was a medication discrepancy. On 03/19/25 during a record review at 4:00 P.M. it was discovered policy was not followed for medication destruction and medication administration. The SRI indicated after a thorough investigation the facility could not conclude misappropriation occurred. The deliberate misplacing or taking of the resident's property without the resident's consent could not be determined as a result of there were no witnesses to misappropriation and the nurse denied any misappropriation. It was found during the investigation that Licensed Practical Nurse (LPN) #801 did not follow the facility policy regarding wasting narcotics and two residents (Residents #25 and #58) received additional doses of narcotics. The investigative findings indicated misappropriation of narcotics was unsubstantiated. Review of the SRI Witness Statement form dated 03/19/25 authored by LPN #801 revealed Resident #25's evening dose came up at 5:30 P.M. on the medication administration record (MAR). When the resident was not in her room or in the dining room, the medication (oxycodone) was wasted and if the resident was located, the medication was administered. When LPN #801 was the only nurse on the hall, LPN #801 did not have a staff member to witness the waste of the oxycodone narcotic pain medication that was not administered When LPN #801 was the only nurse for the hall she was busy. Resident #25 was administered her pain medication when she was in pain because LPN #801 thought Resident #25 had a physician order for as needed oxycodone. Review of the undated SRI investigation form revealed Resident #25's medical record showed the resident received an additional dose of oxycodone narcotic pain medication on 01/15/25 at 11:00 A.M.; 01/16/25 at 3:00 P.M.; 01/18/25 at 3:00 P.M.; 01/29/25 at 8:00 A.M., 02/12/25 at 8:00 A.M.; 02/24/25 at 6:00 A.M. or 9:00 P.M.; 03/01/25 at 12:00 P.M. and an extra dose on 03/01/25 at 1:00 P.M. (two pills); 03/10/25 at 11:00 A.M.; and on 03/12/25 at 7:00 P.M. an additional oxycodone narcotic pain medication was signed off as administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #58's medical record revealed the resident was admitted on [DATE] with diagnoses including senile degeneration of the brain, age-related osteoporosis and generalized anxiety disorder. Review of Resident #58's MDS 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment. Review of Resident #58's physician orders revealed an order dated 10/29/24 for oxycodone 5 mg twice a day to be administered between 6:00 A.M. to 11:00 A.M. and between 6:00 P.M. to 10:00 P.M. Review of the SRI Witness Statement form dated 03/19/25 authored by LPN #801 revealed when administering Resident #58's bedtime medications, at times the family did not want Resident #58 to have medications until the niece came which was anywhere from 7:30 P.M. or beyond. LPN #801 threw away the cup of crushed medications she had placed in pudding. For the waste of the narcotic pain medications, when LPN #801 was the only nurse, LPN #801 had no staff to witness the waste of the narcotic pain medications. LPN #801 was not sure about the extra morning dose of narcotic pain medications except sometimes the narcotic pain medications would get dropped or flung out of the pack. Review of the undated SRI investigation form revealed Resident #58's medical record showed the resident had four pills signed out of the narcotic flow record on 01/16/25 including two oxycodone at 8:00 A.M., one at 2:00 P.M. and one at 8:00 P.M. (two 5 mg tablets were given at 8:00 A.M. when one tablet was ordered, no dose was ordered at 2:00 P.M., and two 5 mg tablets were given at 8:00 P.M. when only one tablet was ordered); on 01/19/25, Resident #58 received an additional dose at 2:00 P.M. (no dose was ordered to be administered at that time); on 01/31/25, documentation revealed two oxycodone narcotic pain medications were removed at 8:00 A.M. and 8:00 P.M. (only one 5 mg tablet was ordered). Interview on 03/31/25 at 1:00 P.M. with Resident #25 denied concerns with pain management or narcotic pain medication administration. Interview on 03/31/25 at 3:00 P.M. with Regional Registered Nurse (RN) #802 confirmed Residents #25 and #58 had approximately 30 oxycodone narcotic pain medications that LPN #801 erroneously administered or wasted without a witness. LPN #801 denied any misappropriation. RN #802 stated LPN #801 had an answer for every question that she was presented and the narcotic drug screen for LPN #801 was negative. It was determined the medications had not been misappropriated, LPN #801 used poor nursing practice. Interview on 03/31/25 at 3:34 P.M. with Resident #58 revealed she had no concerns with pain management or narcotic pain medication administration. Interview on 04/02/25 at 8:54 A.M. with LPN #801 indicated she felt there was a lack of nursing staff and that was the reason she did not get another nurse to waste the narcotics for Residents #25 and #58. She stated she was aware that she was not doing things by protocol and it was lazy. Interview on 04/02/25 at 9:23 A.M. with the Consultant Pharmacist indicated she spot checked the narcotic flow records and was not aware of any diversion of narcotics in the facility. Review of the staffing schedules from 03/09/25 to 03/15/25 revealed RN #801 worked from 6:00 A.M. to 6:00 P.M. and there were multiple nurses in the building during these dates. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Disposal of Medications and Medication-Related Supplies policy dated May 2020 revealed when a dose of a controlled medication was removed from the container for administration but refused by the resident or not administered for any reason, it was not placed back in the container. It was destroyed in the presence of two licensed nurses, and the disposal was documented in the destruction log book. The deficient practice was corrected on 03/21/25 when the facility implemented the following corrective actions: On 03/19/25 at approximately 3:30 P.M. LPN #801 was suspended (her last shift worked was 03/15/25) and would not be returning to work at the facility. On 03/19/25 LPN #801 went for a toxicology screen and the results were returned to the facility on [DATE] at 6:00 P.M. The results were negative. On 03/19/25, Regional RN #802 completed an audit of all current controlled narcotic flow records on all units and the controlled narcotic sheets on the unit LPN #801 worked. No other narcotic discrepancies except Residents #25 and #58 were identified. On 03/19/25, Regional RN #802 completed an audit of all residents narcotic flow records for North one and North two from 01/01/25 to 03/19/25. No other narcotic discrepancies except Residents #25 and #58 were identified. On 03/19/25, the Director of Nursing (DON) educated staff members on General Medication Administration policy and the residents five rights regarding medication administration; Controlled Medication Disposal policy (specific to wasting narcotics); and the Abuse Misappropriation policy. In attendance were RNs #817, #863, #893; LPNs #809, #828, #835, #836, #848, #861, #877, #889, #895, #909, #930; and Certified Medication Aides (CMAs) #811, #858, #866. Attendance was verified by nurse education sign-in sheets. On 03/19/25, a quality improvement meeting was held with Regional RN #802, the Administrator, DON and Medical Director (via telephone) regarding the findings of the missing narcotics investigation and steps moving forward. Beginning on 03/20/25 the DON or designee would educate all agency licensed nurses prior to the nurses working their shift on the floor regarding medication administration and controlled medication disposal policy. The facility did not have any agency staff working from 03/20/25 to 03/31/25. Beginning on on 03/21/25, the DON or designee would audit all current controlled narcotic count sheets two times a week for four weeks to ensure that controlled medications were wasted per facility policy. Beginning on 03/21/25 the DON or designee would audit three random residents three times a week for four weeks to ensure that controlled medications were administered per the physician order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Beginning on 03/21/25 the DON or designee would educate all new staff including LPN #833 (first date of training on medication administration cart on 03/24/25), RN #847 (first date of training on medication administration cart on 03/22/25) and RN #873 (first date of training on the medication administration cart on 03/30/25) during their orientation on the medication administration cart. New staff were required to have supervision on the medication administration cart for a minimum of fourteen 12-hour shifts (or more) on a medication administration cart based on experience. The DON would meet with the new hires prior to the nurses starting on their own to educate the nursing staff on the policies including administering and wasting narcotic pain medications.