

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Altercare of Navarre Ctr for Rehab & Nrsng Care		STREET ADDRESS, CITY, STATE, ZIP CODE  517 Park Street NW Navarre, OH 44662	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</b></p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, interview, investigation review and policy review the facility failed to prevent misappropriation of resident medication. This affected three residents (#10, #11 and #12) of three residents reviewed for misappropriation. The census was 86.</p> <p>Findings include:</p> <p>1. Review of Resident #10's medical record revealed an admitted [DATE] and a discharge date [DATE]. Diagnoses included status post triple aortic repair, peripheral vascular disease, and acute respiratory failure.</p> <p>Review of Resident #10's April 2024 physician orders revealed an order for Oxycodone 5 milligrams (mg) as needed for moderate pain, severe back pain, or breakthrough pain to be given every four hours.</p> <p>Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was receiving an opioid. The assessment was not completed due to the residents' short stay in the facility. The resident was in the facility for two days.</p> <p>Review of the progress notes revealed the resident was admitted back to the hospital on 04/01/24 for infection and status post triple aortic repair.</p> <p>Review of Self-reported incident (SRI) # 246775 dated 04/25/24 revealed the facility received an email from Licensed Practical Nurse (LPN) #100 that stating the narcotic book was signed incorrectly during her shift change indicating that a medication was not accounted for. An audit was completed the same day, and it was discovered that Resident #10's Oxycodone 5 mg was missing from the medication cart along with the pharmacy narcotic sheet. The facility initiated an investigation but unsubstantiated the allegation stating the evidence indicated abuse, neglect or misappropriation did not occur. After a thorough investigation the facility cannot conclude misappropriation occurred. The deliberate misplacing or taking of the resident's property without the resident's consent could not be determined. LPN #100 denied any wrongdoing and her drug screen was negative. Resident discharged to hospital prior to alleged incident.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the monthly control drug report provided by the pharmacy revealed the facility received 24 tablets of Resident #10 Oxycodone 5 mg on 03/30/24 from the pharmacy.</p> <p>Review of the Control Sheet Record log revealed at the beginning of each shift, the nurse signing the count sheet accountability record is accepting responsibility for the number of count sheets present. During the shift, if a new controlled substance is added to the cart, log the entry of the new sheet onto the log; include date, count sheet added, resident's name, drug and strength, nurse signature and witness signature. During the shift, if a controlled substance is discontinued or removed from the cart, make an appropriate entry on the log to subtract from the balance; include date, count sheet removed, resident's first initial and last name, drug and strength/prescription number, number of doses, disposition of the medication, and the nurses signature.</p> <p>Review of the Control Sheet Record log revealed Resident #10's Oxycodone 5 mg was added to the medication cart on 03/30/24. Continued review revealed the medication was never removed from the Control Sheet Record. No witness signature was noted on the record. And no record of the Oxycodone being removed from the narcotic box was documented. The facility was unable to determine where Resident #10's Oxycodone was.</p> <p>Interview on 05/23/24 at with Regional Nurse Consultant (RNC) #200 revealed LPN #100 reported to her agency via email that during shift change LPN #201 stated there were 28 sheets of total narcotics in the medication cart. She believed her but at the end of her shift when she counted there were only 27 cards of narcotics. She was unable to account for the missing medication. The next day an audit was completed which revealed Resident #10's Oxycodone was not accounted for. Because the medication and the sheet were missing, the facility was unable to determine how long it had been missing, how many pills were missing, or where the medication was. She stated there were also missing pages from the Control Sheet Record log where someone had torn them from the ledger. RNC #200 confirmed that the facility was not following their policy related to adding and removing narcotics from the medication cart and cannot account for the missing medication.</p> <p>2. Review of Resident #11's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included secondary malignant neoplasm of large intestine and rectum and encounter for surgical aftercare following surgery on the digestive system.</p> <p>Review of Resident #11's March 2024 physician orders revealed an order for Oxycodone 5 mg by mouth every six hours as needed.</p> <p>Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively impaired and had occasional pain.</p> <p>Review of the progress notes revealed no concerns related to uncontrolled pain.</p> <p>Review of Self-reported incident (SRI) # 246925 dated 04/29/24 revealed during a medication audit on 04/29/24 it was discovered that a sheet for discharged resident, Resident #11, Oxycodone 5 mg was missing. After a thorough investigation the facility cannot conclude misappropriation occurred. The deliberate misplacing or taking of the resident's property without the resident's consent could not be determined. No potential wrongdoer was identified.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the monthly control drug reported provided by the pharmacy revealed the facility received 30 tablets of Resident #11 Oxycodone 5 mg on 03/14/24.</p> <p>Review of the Control Sheet Record log revealed Resident #11's Oxycodone 5 mg was added to the medication cart on 03/14/24. Continued review revealed the medication was never removed from the count. No witness signature was noted on the record. And no record of the Oxycodone being removed from the narcotic box was documented. The facility was unable to determine where the Oxycodone was.</p> <p>Interview on 05/23/24 at with Regional Nurse Consultant #200 revealed after the facility discovered another resident's narcotic medication missing on 04/25/24 they completed additional audits. During the addition audit it was also determined that Resident #11 medication was also removed with the pharmacy slip from the medication cart. The facility was unable to determine when the medication was removed, who removed the medication, and how much of the medication was missing due to missing narcotic log sheets and inaccurate completion of the Control Sheet Records.</p> <p>3. Review of Resident #12's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included fracture of the second lumbar vertebra, encounter for orthopedic aftercare, and chronic kidney disease.</p> <p>Review of Resident #12's March 2024 physician orders revealed an order for Oxycodone 5 mg my mouth every three hours as needed.</p> <p>Review of Resident #12's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was moderately impaired and had occasional pain.</p> <p>Review of Resident #12's progress notes revealed no concerns related to uncontrolled pain.</p> <p>Review of Self-reported incident (SRI) # 246924 dated 04/29/24 revealed during a medication audit on 04/29/24 it was discovered that two medication sheets for discharged resident, Resident #12, Oxycodone 5 mg were missing. After a thorough investigation the facility cannot conclude misappropriation occurred. The deliberate misplacing or taking of the resident's property without the resident's consent could not be determined. No potential wrongdoer was identified.</p> <p>Review of the monthly control drug report provided by the pharmacy revealed the facility received 26 tablets of Resident #12 Oxycodone 5 mg on 03/06/24, and 11 tablets were delivered on 03/07/24. The facility was unable to provide evidence of when the medication was added or removed from the medication cart due to inaccurate narcotic count logs and missing pages.</p> <p>Review of the Control Sheet Record log from 03/2024 through 04/24/24 revealed inconsistencies with adding and removing medications from the narcotic boxes, nurses witnessing narcotic removals, and whole pages missing from the logs. There was no evidence indicating that Resident #12's medication was ever removed from the narcotic box in the medication cart.</p> <p>Interview on 05/23/24 at 3:00 P.M. with LPN #201 revealed she had no inconsistencies with the count sheet when she counted with LPN #100 during shift change. She reported at that time the medication card was accurate. She reports she is not sure what happened during LPN #100's shift.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/23/24 at 3:10 P.M. with Regional Nurse Consultant #200 revealed after the facility discovered another resident's narcotic medication missing on 04/25/24 they completed additional audits. During the addition audit it was also determined that Resident #12 medication was also removed with the pharmacy slip from the medication cart. The facility was unable to determine when the medication was removed, who removed the medication, and how much of the medication was missing due to missing narcotic log sheets and inaccurate completion of the Control Sheet Records.</p> <p>Review of the facility policy, Disposal of Medications and medication-related Supplies (dated 05/2020) revealed all controlled medications remaining in the facility after a resident has been discharged or the order is discontinued are disposed of within 10 days in the facility by two of the following individuals the DON, licensed nursing supervisor, manager, DON designee, or another pharmacy or pharmacist-approved supervisory level nurse. All discontinued controlled medications must be kept locked in the control drawer and shift to shift counts must be performed until removed by the DON or designee.</p> <p>Review of the undated facility policy, Abuse, Mistreatment, Neglect, Injuries of Unknown Source, and Misappropriation of Resident Property revealed misappropriation means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of the resident's belongings or money without the resident's consent. The policy stated the facility will not tolerate misappropriation of resident property by anyone.</p> <p>The deficiency was corrected on 05/06/24 after the facility implemented the following corrective actions:</p> <p>On 4/25/24 between 10:00 A.M. and 3:00 P.M., the DON and Interim ADON, went to the 100 hall to audit the shift-to-shift count log. During the audit, they could not account for discharged resident (Resident #10) one card of Oxycodone 5 mg. All other narcotics were accounted for on this cart.</p> <p>On 4/25/24 at 11:30 A.M. the Administrator called the agency to remove LPN #100 from the schedule pending investigation.</p> <p>On 4/25/24 at 3:30 P.M., the Administrator opened a SRI for Misappropriation. Staff education on Abuse, Neglect, and Misappropriation initiated by the Administrator and DON.</p> <p>On 4/25/24 at 3:37 P.M. the Administrator requested LPN #100's information for SRI reporting purposes.</p> <p>On 4/25/24 around 4:00 P.M. nurses' interviews started. Interviews were completed with nurses that have worked the 400 unit in the past 30 days. The interviews were conducted by the Administrator and Regional Nurse Consultant #200.</p> <p>On 4/25/24 around 4:00 P.M., resident interviews completed with no negative findings by the Administrator.</p> <p>On 4/25/24 at 5:19 P.M., information was provided from LPN #100's agency and informed the LPN #100 was going to Work, Health, and Safety for drug screen.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/26/24, Regional Nurse Consultant #200 arrived to facility around 12:00 P.M. and began an audit of all medication carts for shift-to-shift count logs. Request was made to Pharmacy for record of all narcotics delivered to facility from March 1, 2024 to current. All narcotic count sheets gathered. Regional Nurse Consultant #200, the DON, and Interim ADON, began an audit of accounting for all narcotics delivered from March 1, 2024, to current by utilizing actual count sheets and destruction log. This continued through the duration of the workday. No missing medications noted at this time.</p> <p>On 4/28/24 at 6:36 P.M. the Administrator, DON, and Corporate Human Resource Manager received drug screen results for LPN #100 which were negative.</p> <p>On 4/29/24 at 8:00 A.M., Regional Nurse Consultant #200, the DON, and ADON, resumed auditing all medication cards. This audit concluded around 3:30 P.M. and revealed that discharged resident (Resident #11) had one card of Oxycodone 5 mg and discharged resident (Resident #12) had two cards of Oxycodone 5 mg unaccounted for.</p> <p>On 4/29/24 at 3:50 P.M., Regional Nurse Consultant #200 opened SRI 246924 and SRI 246925.</p> <p>On 4/29/24 at 4:00 P.M., the DON initiated education on shift-to-shift controlled medication logs with all the facility nurses and agency nurses.</p> <p>On 4/29/24 around 4:00 P.M., resident interviews were completed with no negative findings by Regional Nurse Consultant #200 and the Administrator.</p> <p>On 05/02/24 additional nurse interviews were completed for all nurses that have worked the 100 and 400 units in the past 30 days with no findings.</p> <p>On 05/03/24 education was completed for all nurses for shift-to-shift controlled medication logs by Regional Nurse Consultant #200.</p> <p>On 05/03/24 education was completed for all nurses and STNAs for Abuse, Neglect, and Misappropriation by Regional Nurse Consultant #200 and the Administrator.</p> <p>On 05/06/24 audits for medication carts shift-to-shift controlled substance logs were initiated. Audits are scheduled to be completed three times a week on all medication carts for all residents by the DON or designee to ensure ongoing compliance.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153589</p>		