STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365482	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Navarre Ctr for Rehab & Nrsg Care	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)
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** 34297 Based on observation, record review and interview, the facility failed to ensure wound care was completed as ordered for Residents #43, #51 and #77 and timely wound assessments were completed for Resident #77. This finding affected three (Residents #43, #51 and #77) of four residents reviewed for wounds. Findings include: 1. Review of #51's medical record revealed the resident was admitted on [DATE] with diagnoses including other acute osteomyelitis of the right ankle and foot, encounter for other orthopedic aftercare and end stage renal disease. Review of Resident #51's hospital report dated 12/09/24 revealed the resident had a right lower extremity non healing wound with osteomyelitis related to advanced peripheral vascular disease and insulin dependent diabetes. Review of Resident #51's care plans revealed an intervention dated 12/10/24 indicated to note amount and characteristics of any wound drainage, and observe effectiveness of ordered treatments. Notify the physician as needed. Review of Resident ##51's physician orders revealed an order dated 12/10/24 for Ceftazidime 2 grams intravenous (IV) during dialysis for six weeks once a day on Tuesday, Thursday and Saturday; an order dated 12/10/24 for Vancomycin 750 milligrams (mg) IV during dialysis on Tuesday, Thursday and Saturdays for osteomyelitis; and an order dated 12/30/24 to cleanse the right foot wound with wound cleanser, pat dry, apply black foam and secure and place negative pressure wound therapy (NPWT or a special type of wound dressing that was used in a therapy system to help the wound heal) at 125 mmHg (millimeters of mercury or a unit of pressure that measures how high a column of mercury rises). Change every Monday, Wednesday and Friday and as needed. Review of Resident #51's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #51's Wound Information Observation History dated 12/30/24 at 2:18 P.M. revealed the resident had a right heel surgical incision which measured 6 cm (centimeters) length by 2 cm width. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/02/25 at 5:59 A.M. with Resident #51 indicated she had a wound vac on her left foot and denied concerns with the treatments on her left foot wound. She did not report any other concerns. Observation at the time of the interview revealed the wound vac settings was noted at 135 mmHg. Interview on 01/02/25 at 6:02 A.M. with Registered Nurse (RN) #805 indicated she was aware the facility had an agency nurse working as the wound nurse and she had not been completing the wound care for a couple of weeks. Interview on 01/02/25 at 6:46 A.M. with Licensed Practical Nurse (LPN) #810 indicated she was an agency nurse which was hired to do wound care in the facility, but she was pulled to the floor approximately four weeks ago. She stated the floor nurses were required to do their own wound care and most of them were not doing it. Observation on 01/02/25 at 9:00 A.M. and subsequent confirmation interview with RN Regional #812 confirmed Resident #51's wound vac was set at 135 mmHg and the physician order was 125 mmHg. 2. Review of Resident #43's medical record revealed the resident was admitted on [DATE] with diagnoses including necrotizing fasciitis, polyneuropathy and muscle weakness. Review of Resident #43's care plans revealed an intervention dated 01/26/24 to perform the current treatments as orders and observe the treatment for effectiveness. Review of Resident #43's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #43's medication administration records (MARS) and treatment administration records (TARS) from 12/03/24 to 01/02/25 revealed LPN #813 documented on the TAR that she completed Resident #43's wound care on 01/01/24. Review of Resident #43's physician orders revealed an order dated 12/16/24 to cleanse the left lower extremity with normal saline, pat dry, apply Triamcinolone Acetonide cream 0.025%, collagen, an adaptic non-stick dressing, an abdominal pad (ABD) and Kerlix once daily and as needed. Review of resident #43's Wound Information Observation History form dated 12/30/24 at 11:38 P.M. revealed the resident had a venous ulcer to the left shin and left lower leg which measured 6 cm length by 14. 5 cm width. Interview on 01/02/25 at 6:02 A.M. with RN #805 indicated she was aware the facility had an agency nurse working as the wound nurse and she had not been completing the wound care for a couple of weeks. Interview on 01/02/25 at 6:46 A.M. with LPN #810 indicated she was an agency nurse which was hired to do wound care in the facility, but she was pulled to the floor approximately four weeks ago. She stated the floor nurses were required to do their own wound care and most of them were not doing it. Observation on 01/02/25 at 6:59 A.M. with LPN #810 of Resident #43's left anterior (top) foot dressing revealed the dressing was completed on 12/31/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/02/25 at 7:01 A.M. with LPN #810 confirmed Resident #43's left anterior foot dressing was not completed on 01/01/24 as required. 3. Review of Resident #77's medical record revealed the resident was admitted on [DATE] with diagnoses including other acute osteomyelitis of the left ankle and foot, diabetes and partial traumatic amputation of the left foot. Review of Resident #77's Quarterly MDS 3.0 assessment dated [DATE] revealed intact cognition. Resident #77 was discharged to the hospital on 11/15/24 and returned 11/22/24, discharged to hospital on 11/25/24 and returned 12/02/24. Review of Resident #77's physician orders revealed an order dated 12/02/24 (discontinued 12/23/24) to cleanse the left foot with normal saline, apply lodoform packing and a dry dressing to the left foot, apply betadine wet to dry to left heel and silver alginate and an abdominal (ABD) dressing to the anterior ankle, wrap the leg with an ace bandage daily and as needed. Review of Resident #77's physician orders revealed an order dated 12/02/24 (discontinued 12/23/24) to cleanse the right foot with normal saline, apply lodoform to the proximal medial calf wound followed by silver alginate and an abdominal pad to the posterior right leg wound and anterior right leg wound, wrap with an ace bandage and change daily. The facility did not have assessments of Resident #77's wounds from 12/02/24 to 12/18/24. Resident discharged to hospital from 12/18/24 and returned to the facility on [DATE]. Review of Resident #77's care plans revealed an intervention dated 12/31/24 to perform current treatments as ordered and observe for effectiveness. Review of Resident #77's wounds upon return from the hospital revealed the following: Wound #2: Review of Resident #77's Wound Management Detail Report dated 12/30/24 at 10:26 A.M. revealed the resident had a surgical incision of the left second toe amputation site which measured 4 cm length by 1.5 cm width by 0.3 cm depth. Review of Resident #77's physician orders revealed an order dated 12/31/24 to cleanse the left amputation site with wound cleanser, pat dry, apply calcium alginate with silver, an ABD, Kerlix and tubi grip from toes to knee once daily. Wound #3: Review of Resident #77's Wound Management Detail Report form dated 12/30/24 at 10:43 A.M. revealed the resident had a left calf venous ulcer which measured 3 cm length by 4 cm width by 0.1 cm depth. Review of resident #77's physician orders revealed an order dated 12/31/24 to cleanse the left calf with wound cleanser, pat dry, apply calcium alginate with silver, an ABD pad, Kerlix and tubi grip from toes to knee once daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound #4: Review of Resident #77's Wound Management Detail Report dated 12/31/24 at 10:21 A.M. revealed the resident had an unspecified ulcer type to the right knee which measured one cm length by one cm width first identified 12/31/24. Review of Resident #77's physician orders revealed an order dated an order dated 12/31/24 to cleanse the right knee with wound cleanser, pat dry, apply calcium alginate with silver, an abdominal dressing, Kerlix and tubi grip from toes to the knee. Wound #5: Review of Resident #77's physician orders revealed an order dated 12/31/24 to cleanse the right calf wound with wound cleanser, pat dry, apply triad, an abdominal pad, Kerlix and tubi grips from toes to knees once daily Wound #6: Review of Resident #77's Wound Management Detail Report form dated 12/30/24 at 10:14 A.M. revealed the resident had a venous ulcer to the right shin which measured 1 cm length by one cm width by 0. 1 cm depth which was identified on 12/30/24. Review of Resident #77's physician orders revealed an order dated 12/31/24 to cleanse the right shin with wound cleanser, pat dry, apply triad, an ABD, Kerlix and tubi grips from toes to the knee once daily. Wound #7: Review of Resident #77's physician orders revealed an order dated 12/31/24 to apply skin prep to the bilateral heels every shift. Interview on 01/02/25 at 6:02 A.M. with RN #805 indicated she was aware the facility had an agency nurse working as the wound nurse and she had not been completing the wound care for a couple of weeks. Interview on 01/02/25 at 6:46 A.M. with LPN #810 indicated she was an agency nurse which was hired to do wound care in the facility, but she was pulled to the floor approximately four weeks ago. She stated the floor nurses were required to do their own wound care and most of them were not doing it. Observation on 01/02/25 at 7:04 A.M. with LPN #810 of Resident #77's bilateral lower extremity dressings were dated 12/31/24 (one long dressing on each leg which included Kerlix and tube grips from the toes to the knee). Interview on 01/02/25 at 7:05 A.M. with LPN #810 confirmed Resident #77's wound care was not completed as ordered. Interview on 01/02/25 at 12:01 P.M. with RN Regional #812 confirmed the facility did not have evidence of wound assessments including sizing and staging if applicable for Resident #77's wounds from 12/02/24 to 12/18/24. Review of the undated Wound Care policy revealed it was the facility's policy to provide guidelines for the care of wounds to promote healing. This deficiency represents non-compliance investigated under Complaint Number OH00160611.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review and interview, the facility failed to ensure Resident #77's pressure ulcer wound care was completed as ordered. This finding affected one (Resident #77) of four residents reviewed for wound care. Findings include: Review of Resident #77's medical record revealed the resident was admitted on [DATE] with diagnoses including other acute osteomyelitis of the left ankle and foot, diabetes and partial traumatic amputation of the left foot. Review of Resident #77's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed intact cognition. Review of Resident #77's podiatrist note dated 11/12/24 revealed the resident had a stage three pressure ulcer of the left heel. Review of Resident #77's physician orders revealed an order dated 12/02/24 (discontinued 12/23/24) to cleanse the left foot with normal saline, apply Iodoform packing and a dry dressing to the left foot, apply betadine wet to dry to left heel and silver alginate and an abdominal (ABD) dressing to the anterior ankle, wrap the leg with an ace bandage daily and as needed. Review of Resident #77's medical record revealed no evidence the facility assessed the resident's left heel pressure ulcer. Resident #77 was discharged to the hospital on 12/18/24 and returned to the facility on [DATE]. Review of Resident #77's podiatrist note dated 12/22/24 (initial consult in hospital) revealed a decubitus ulcer of left heel stable with no signs or symptoms of infection. No pressure ulcer staging was noted on the form. Review of Resident #77's care plans revealed an intervention dated 12/31/24 to perform current treatments as ordered and observe for effectiveness. Review of Resident #77's physician orders revealed an order dated 12/31/24 to cleanse the left heel with wound cleanser, pat dry, apply calcium alginate with silver, an abdominal pad, Kerlix and tubi grip from toes to knee once daily. Review of Resident #77's unstageable left heel Wound Management Detail Report form dated 12/30/24 at 10:38 A.M. revealed the resident had an unstageable pressure wound which measured 3 cm length by 5 cm width by 0.3 cm depth with slough and/or eschar. Interview on 01/02/25 at 6:02 A.M. with Registered Nurse (RN) #805 indicated she was aware the facility had an agency nurse working as the wound nurse and she had not been completing the wound care for a couple of weeks. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/02/25 at 6:46 A.M. with Licensed Practical Nurse (LPN) #810 indicated she was an agency nurse which was hired to do wound care in the facility, but she was pulled to the floor approximately four weeks ago. She stated the floor nurses were required to do their own wound care and most of them were not doing it. Observation on 01/02/25 at 7:04 A.M. with LPN #810 of Resident #77's bilateral lower extremity dressings were dated 12/31/24 (one long dressing on each leg which included Kerlix and tube grips from the toes to the knee). Interview on 01/02/25 at 7:05 A.M. with LPN #810 confirmed Resident #77's pressure wound care was not completed as ordered. Interview on 01/02/25 at 12:01 P.M. with RN Regional #812 confirmed the facility did not have wound assessments including sizing and staging if applicable for Resident #77's pressure wound from 12/02/24 to 12/18/24. Review of the undated Pressure Injuries: Assessment, Prevention and Treatment policy revealed it was the facility's policy to identify residents at risk for developing pressure injuries, implement interventions to prevent the development of pressure injuries and provide care for existing pressure injuries. This deficiency represents non-compliance investigated under Complaint Number OH00160611.