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	01/30/2025

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 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** 34298 Based on record review and interview, the facility failed to ensure Resident #8's responsible party was notified of new orders and changes in Resident #8's condition. This affected one (Resident #8) of three residents reviewed for notifications. The facility census was 83. Findings include: Review of the medical record revealed Resident #8 was admitted on [DATE] with diagnoses that included Alzheimer's disease, hyperlipidemia, osteoporosis, hypothyroidism, hypotension, insomnia, adult failure to thrive, major depressive disorder, anxiety disorder, and hypertension. Review of a progress note dated 12/02/24 revealed Resident #8 was in isolation for Covid positive precautions. A progress note dated 12/14/24 revealed Resident #8 was administered an oral antibiotic for a urinary tract infection. Review of the physician orders revealed cephalexin 500 milligrams (mg) twice a day from 12/14/24 through 12/21/24 for a urinary tract infection. Review of physician orders revealed on 01/04/25 Resident #8 had new orders for acetaminophen (for mild pain) 1000 milligrams (mg) every six hours as needed, albuterol sulfate (to prevent and treat difficulty breathing) inhaler two puffs every four hours as needed, amlodipine (to treat high blood pressure) five mg daily, atorvastatin (to treat high cholesterol) 40 mg daily, and azathioprine (immunosuppressive) 100 mg daily. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had severe cognitive impairment. An interview on 01/29/25 at 10:20 A.M. Regional Nurse Consultant verified Resident #8 had acetaminophen, albuterol sulfate, amlodipine, atorvastatin,and azathioprine entered as new orders on 01/04/25. The five medications entered into Resident #8's medical record were for Resident #84, who was admitted on [DATE]. Resident #8 had a fall on 01/07/25 and the nurse practitioner reviewed Resident #8's medications and found the error. (continued on next page)

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	On 01/29/25 at 10:20 A.M. the Regional Nurse Consultant verified Resident #8's responsible party was not notified of the new orders for medication on 01/04/25. On 01/30/25 at 8:40 A.M. the Regional Nurse Consultant verified Resident #8 tested positive for Covid on 11/28/24 and there was no documentation of Resident #8's representative being notified. The Regional Nurse Consultant also verified there was no documentation of Resident #8's representative being notified of new orders for an antibiotic on 12/14/24. This deficiency represents non-compliance investigated under Master Complaint Number OH00161501.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, interview and policy review the facility failed to prevent Resident #8 from receiving the wrong medication. This affected one (Resident #8) of three residents reviewed for medications. The facility census was 83. Findings include: Review of the medical record revealed Resident #8 was admitted on [DATE] with diagnoses that included Alzheimer's disease, hyperlipidemia, osteoporosis, hypothyroidism, hypotension, insomnia, adult failure to thrive, major depressive disorder, anxiety disorder, and hypertension. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had severe cognitive impairment. Review of physician orders revealed on 01/04/25 Resident #8 had new orders for acetaminophen (for mild pain) 1000 milligrams (mg) every six hours as needed, albuterol sulfate (to prevent and treat difficulty breathing) inhaler two puffs every four hours as needed, amlodipine (to treat high blood pressure) five mg daily, atorvastatin (to treat high cholesterol) 40 mg daily, and azathioprine (immunosuppressive) 100 mg daily. Review of the medication administration record (MAR) revealed Resident #8 received amlodipine, atorvastatin and azathioprine on 01/04/25, 01/05/25, 01/06/25, and 01/07/25. An interview on 01/29/25 at 10:20 A.M. Regional Nurse Consultant verified Resident #8 had acetaminophen, albuterol sulfate, amlodipine, atorvastatin,and azathioprine entered as new orders on 01/04/25. The five medications entered into Resident #8's medical record were for Resident #84 who was admitted on [DATE]. Resident #8 had a fall on 01/07/25 and the nurse practitioner reviewed Resident #8's medications and found the error. Regional Nurse Consultant verified Resident #8 received four doses of amlodipine five mg, atorvastatin 40 mg, and azathioprine 100 mg before the error was discovered. Review of the facility's undated Medication Error Policy and Procedure revealed the facility strives to ensure that medications are administered to each resident without complications. The facility recognizes the potential of human /computer/ computation error with medication administration. The facility has medication administration guidelines to help reduce the risk of a medication error. However, in the event of a medication error, the safety and well-being of the resident is the highest priority for quality assurance and performance improvement. The National Coordinating Council for Medication Error and Prevention defines a Medication Error as follows: A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer. Such events may be related to professional practice, procedures and systems, include prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use. The deficient practice was corrected on 01/14/25 when the facility implemented the following corrective actions: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/07/25 at approximately 4:00 P.M., it was discovered by the Certified Nurse Practitioner (CNP) that Resident #8 had received medications amlodipine five mg, atorvastatin 40 mg, and azathioprine 100 mg. On 01/07/25 at approximately 4:10 P.M. amlodipine five mg, atorvastatin 40 mg, and azathioprine 100 mg were discontinued for Resident #8. New orders were received for Resident #8 to have vital signs checked every eight hours for the next 72 hours. On 01/07/25 at approximately 5:00 P.M. the Regional Nurse Consultant discovered amlodipine five mg, atorvastatin 40 mg, and azathioprine 100 mg was originally ordered for Resident #84 but entered as orders for Resident #8. On 01/07/25 at approximately 5:15 P.M. the Regional Nurse Consultant notified the Medical Director of the medication error. On 01/08/25 the Regional Nurse Consultant began to audit all new admissions from 01/03/25. Regional Nurse Consultant reviewed the admission orders to ensure the orders were entered correctly. The Regional Nurse Consultant continued audits until 01/24/25. On 01/08/25 the Licensed Nursing Home Administrator (LNHA) notified Resident #8's responsible party of the medication error. On 01/08/25 the LNHA attempted to notify Resident #84's responsible party of the medication error. On 01/08/25 the Regional Nurse Consultant educated eleven licensed practical nurses and ten registered nurses on transcribing orders from the provider and/or upon admission to ensure that the right patient, the right drug, the right time, the right dose, and the right route was followed. On 01/09/25 an Ad Hoc (unplanned) Quality Assurance was completed and the facility alleged compliance on 01/14/25. The Director of Nursing or designee will audit all new admission daily for four weeks and then as needed to ensure that all medications were transcribed correctly. This deficiency represents non-compliance investigated under Master Complaint Number OH00161501.