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	04/21/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Resident #54's dignity was maintained at all times. This affected one resident (Resident #54) of three residents reviewed for dignity. The facility census was 86.Review of the medical record for Resident #54 revealed an admission date of 07/03/25 with diagnoses included hypertension, atrial fibrillation, and legal blindness. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #54 had intact cognition. Resident #54 required extensive assistance for all activities of daily living. Review of the physician's order dated 07/17/25 revealed Resident #54 was dependent for shaving and required shaving weekly. Review of the care plan dated 01/19/26 revealed Resident #54 was unable to perform activities of daily living. Interventions included to perform nail and hair care weekly with showers and to assist with and or shave facial hairs. Review of the facility shower schedule revealed Resident #54 was scheduled for showers every Monday and Thursday. Review of the shower sheets for Resident #54 from 03/12/26 to 04/13/26 revealed she received a shower or a bed bath twice a week as scheduled. No documentation was found related to facial hair. Observation on 04/13/26 at 1:00 P.M. revealed Resident #54 lying in bed sleeping with long full facial hair. Interview on 04/15/2026 145 P.M. with Resident #54 revealed she wanted staff to take care of her facial hair but reported they had not taken care of them in a while. Observation during the interview revealed that Resident #54 still had a face full of facial hair. Interview on 04/15/26 at 2:00 P.M. with Certified Nursing Assistant (CNA) #635 and Registered Nurse (RN) Supervisor #610 reported Resident #54 gets showers on Monday and Thursday afternoons, and they take care of her facial hair then. CNA #635 and RN Supervisor #610 confirmed Resident #54 has not had her facial hair cared for in a while due to the length of the hair. Interview on 04/16/26 at 2:45 P.M. with CNA #587 confirmed that Resident #54 gets shaved ever Monday with her bath or shower. She confirmed she did not shave Resident #54 during her shower on 04/13/26. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy shaving a resident, updated 05/01/25, revealed it is the facility's policy to promote resident hygiene by assisting a resident with removal of facial hair as needed. This deficiency represents non-compliance investigated under Complaint Numbers 2793933 and 2690512.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 interview and record review the facility failed to notify Resident #98's representative of a change in condition. This affected one (Resident #98) of three residents reviewed for notification of change in condition. The facility census was 86.Findings include:Review of the medical record for Resident #98 revealed an admission date of 01/19/26 and a discharge date of 02/10/26 with diagnoses including metabolic encephalopathy, acute and chronic respiratory failure with hypoxia, osteoporosis, and end stage renal disease.Review of the face sheet for Resident #98 revealed she was listed as the primary contact and her mother was also listed as a primary contact.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #98 had moderate cognitive impairment. Resident #98 required extensive assistance for all activities of daily living.Review of the care plan dated 01/31/26 revealed Resident #98 had a risk for pathological injuries/falls and pain related to osteoporosis. Interventions included to keep personal items within reach and to keep the call light within reach at all times.Review of the nursing progress note dated 02/04/26 at 7:37 P.M. revealed Resident #98 was requesting to go to the hospital due to right shoulder pain. Resident #98 reported her shoulder had been hurting since the day prior and was refusing Tylenol as needed for pain. The nurse practitioner was notified and an x-ray of her right shoulder was ordered and ibuprofen for pain. Resident #98 initially refused to have the x-ray completed in the facility and the ibuprofen but then reported she would agree to the treatment and if it still hurt the next day she would go. There was no evidence Resident #98's representative was notified of the pain to shoulder, x-ray, and request for hospitalization. Review of the nursing progress note dated 02/05/26 at 9:14 A.M. revealed while Resident #98 was at the dialysis center, dialysis sent her to the hospital for evaluation due to hypoglycemia. There was no evidence Resident #98's representative was notified the resident was sent to the hospital.Interview on 04/20/26 at 10:22 A.M. with Regional Nurse #649 reported Resident #98's mother was not notified of the change in condition for Resident #98 because Resident #98 was alert and oriented and listed as primary contact.This deficiency represents non-compliance investigated under Complaint Number 2795522.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to care plan a peripherally inserted central catheter (PICC) line for Resident #98. This affected one resident (Resident #98) of six residents reviewed for care plans. The facility census was 86. Review of the medical record for Resident #98 revealed an admission date of 01/19/26 and discharge date of 02/10/26 with diagnoses included metabolic encephalopathy, chronic diastolic heart failure, peripheral vascular disease, and end stage renal disease. Review of the orders for Resident #98 revealed an order dated 01/27/26 revealed an order to schedule an appointment for PICC line removal. No other PICC line orders were observed. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #98 had mild cognitive impairment and required extensive assistance for all activities of daily living. Review of the comprehensive care plan dated 01/23/26 revealed no documentation related to the PICC line. Interview on 04/20/26 at 10:22 A.M. with Regional Nurse #649 confirmed there was no care plan developed for Resident #98's PICC line or documentation of care. This deficiency represents non-compliance investigated under Complaint Numbers 2727070, 2795522, and 2690512.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure care plans were revised for weight loss. This affected two residents (Residents #84 and #101) of six residents reviewed for nutrition. The facility census was 89. Findings Include:1. Resident #84 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage, traumatic brain injury, legal blindness, overactive bladder, psychosis, visual hallucinations, delusional disorder, anxiety disorder, epilepsy, chronic pain, and major depressive disorder. Review of Resident #84's nursing progress notes revealed on 04/04/26 at 2:17 P.M. Registered Dietician (RD) #650 documented the resident had a significant weight loss at the 180 day marker with March weights. Weight loss was appropriate due to her Body Mass Index (BMI) of 25.3 being overweight for her height. RD #650 noted the resident's meal intakes were varied and the resident's oral intake would be monitored and if there was a need for nutritional supplements if weight loss continues. Review of Resident #84's nursing progress notes revealed on 04/14/26 at 2:05 P.M. RD #650 noted an order for her to speak to the resident due to weight loss. RD #650 previously addressed weight loss on 04/04/26 and the resident stated she is happy with her weight at this time and refuses nutritional supplements. RD #650 will continued to monitor for weight loss and needed interventions as resident is agreeable. Review of Resident #84's nursing progress notes revealed on 04/15/26 at 9:08 A.M. RD #650 documented the resident's reweight was 138.7 pounds. RD #650 will continued to monitor and encourage kilocalories (kcal) supplements if the resident was agreeable. Resident #84 does not want kcal supplements at this time and is happy with her current body weight. RD #650 will continue to monitor weekly weights. Review of Resident #84's weights revealed resident was admitted on [DATE] and the first weight obtained was on 10/03/25 at 168 pounds. The resident's weight on 04/16/26 was 138.7 pounds indicating a significant weight loss of 17.4%. No weights were obtained in December 2025 or January 2026. Review of Resident #84's comprehensive quarterly Minimum Data Set (MDS) 3.0, dated 01/27/26, revealed the resident was cognitively intact, the resident's height was 61 inches and her weight was 143 pounds. Answers to the questions of whether there was a weight loss of 5% or more in the last month or 10% or more in the last six months was answered no. Review of Resident #84's care plan for nutrition, last reviewed on 02/04/26, revealed the resident was at risk for altered nutrition related to a BMI of 32.9 indicating class I obesity. Monitor appetite and weight as resident is a new admit. On 11/17/25 the resident's BMI was 30.3 again indicating class I obesity. No significant weight loss at this time. On 02/04/26 the resident's BMI was 27.1 which is overweight for the resident's height. The resident had no significant weight loss however her weight has decreased and the weight loss is appropriate due to her BMI.The goals were to receive adequate nutrition and have no significant weight loss. Supplements were to be provided per physician's orders. RD #650 was to be notified if a significant weight loss of 5% was observed. The care plan was not revised after significant weight loss was identified. Interview with RD #650 on 04/21/26 at 10:40 A.M. revealed Resident #84's weight loss was a positive thing. Her BMI remains a bit high and the resident refuses supplements at this time. The resident is on weekly weights. The weights were reviewed for Resident #84 as well as the physician's orders. Weekly weights were not obtained and the physician's orders revealed no order for weekly weights. RD #650 said she is unable to do anything about the facility obtaining weights. She puts a list out weekly on the nursing units as to who needs weights but she is unable to get the requested weights or reweights. When questioned why there was not a physician's order for weekly weights RD #650 stated she is not able to write orders. RD #650 said usually NP #658 notifies her when a resident has significant weight loss. RD #650 confirmed she had not updated the nutrition care plan to reflect the resident's significant weight loss. 2. Resident #101 was admitted to the facility on [DATE] and was discharged home on [DATE]. The admitting diagnoses included acute and chronic respiratory failure (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with hypoxia, Influenza A, high blood pressure, heart disease, atrial fibrillation, pulmonary fibrosis, asthma, a pacemaker, depression, pneumonia, congestive heart failure, and oxygen dependent. Review of the physician's orders for Resident #101 revealed on 01/27/26 an order was written for the resident to received four ounces of house supplement with meals. On 01/28/26 and order was written to obtain weekly weights for four weeks. On 01/29/26 two ounces of liquid protein was ordered three times a day to assist with wound healing. On 01/30/26 a packet of Juven was ordered daily also for wound healing. Review of the nursing progress notes for Resident #101 revealed on 01/28/26 at 10:30 A.M. RD #650 completed an initial nutrition assessment. The skin assessment said to see the nursing wound grids. The resident's height was listed as 72 inches and the weight was listed as 163.8 pounds. The resident's BMI was listed as within normal range. Resident #101 reported no issues upon admission. Meal intakes had varied since admission. Nursing reported no edema upon admission. The resident receives Vitamin B12 and Iron to support nutrition. The resident was ordered four ounces of house supplement with all meals, two ounces of liquid protein three times a day and one packet of Juven twice a day for wound healing. RD #650 said she would monitor appetite and weight as the resident is a new admit. Review of Resident #101's weights revealed no weights were obtained at any time throughout the resident's stay in the facility. Review of Resident #101's comprehensive MDS admission assessment revealed the resident was cognitively intact, had two pressure ulcers present upon admission, had a height of 72 inches and a weight of 164 pounds. The resident had no known weight loss or gain. Resident #101 had a nutrition care plan initiated, on 01/28/26, which indicated the resident was at risk for altered nutrition related to an order of a cardiac diet, regular texture, and thin liquids. The care plan recommended a regular diet, thin liquids, and no added salt. The goal was for the resident to receive adequate nutrition to meet estimated nutrition needs as evidenced by no significant weight change and no skin breakdown. Interventions were to monitor weekly weights for four weeks then monthly if stable. Interview with RD #650 on 04/21/26 at 10:40 A.M. revealed she provided a list of weights to be obtained by nursing but it often was not completed. She was unaware no weights were obtained throughout Resident #101's stay and the care plan should have reflected the resident was admitted with wounds and already had skin breakdown. This deficiency represents noncompliance for Complaint Numbers 2727070 and 2690512.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed timely assist Resident #17 with activities of daily living (ADLs). This affected one resident (Resident #17) out of 13 reviewed for ADL care. The facility census was 89. Findings include: Review of the medical record for Resident #17 revealed an admission date of 11/05/20 with diagnoses including chronic respiratory failure, bipolar disorder, herpes viral infection, and dementia. Review of the care plan dated 11/21/20 revealed Resident #17 had an impaired ability to perform or participate in daily activities of daily living (ADL) care related to diabetes mellitus, neuropathy, weakness, debility, chronic respiratory failure, anemia, morbid obesity, arthritis, back pain, and shortness of breath on exertion and when lying flat. Interventions included provide assistance with all ADL care and mobility as needed and anticipate resident needs as able implemented 11/21/20, and mechanical lift with assistance of two staff for transfers implemented 06/05/24, Review of the care plan dated 03/14/21 revealed Resident #17 was incontinent of bladder and at risk for altered dignity, skin breakdown, and urinary tract infections. Interventions included provide incontinence care as needed implemented 06/10/24. Review of the care plan dated 03/14/21 revealed Resident #17 was incontinent of bowel and at risk for altered dignity, skin breakdown, diarrhea, and constipation. Interventions included provide incontinence care as needed implemented 03/14/21. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had moderately impaired cognition with a brief interview for mental status (BIMS) score of 10 out of 15. The assessment indicated Resident #17 was frequently incontinent of bladder and bowel, and was dependent for toileting hygiene. On 04/16/26 at 9:03 A.M., an observation revealed Resident #17's call light was activated. At 9:04 A.M., Medical Records Coordinator #503 entered Resident #17's room, Resident #17 said she needed changed, and Medical Records Coordinator #503 deactivated Resident #17's call light at that time. At 9:12 A.M., Resident #17 activated her call light again. At 9:16 A.M., Medical Records Coordinator #503 entered Resident #17's room, Resident #17 said she still needed to be changed, and Medical Records Coordinator #503 deactivated Resident #17's call light at that time. No other staff were observed entering Resident #17's room from 9:16 A.M. to 9:34 A.M. On 04/16/26 at 9:34 A.M., an interview with Resident #17 confirmed nobody had come to change her yet. On 04/16/26 at 9:34 A.M., an interview with Certified Medication Aide (CMA) #529 stated she was unaware Resident #17 needed changed. On 04/16/26 at 9:37 A.M., observation revealed CMA #529 and Certified Nursing Assistant (CNA) #544 entered Resident #17's room to perform incontinence care, approximately 34 minutes after Resident #17 initially requested assistance. On 04/16/26 at 9:45 A.M., an interview with Regional Registered Nurse (RN) #649 stated it was not typically policy to deactivate the call light without addressing the need. She further stated if someone (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who was unable to provide the requested care answered the call light, they could turn the call light off and go get someone who could provide the care. Review of the facility policy titled Call Light – Answering, dated 05/01/25, revealed call lights would be answered timely to meet resident needs. The procedure for staff included answering the call light as soon as possible, knocking on the door and introducing themselves, turning the call light off, listening to the resident's request, providing the service requested or informing the resident that their request needs to be fulfilled by the nurse, and following up on their request promptly. This deficiency represents non-compliance investigated under Complaint Numbers 2637021 and 2616336.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and interview, the facility failed to ensure the physician or nurse practitioner (NP) was notified promptly of Resident #104's change in condition, failed to ensure Residents #7 and #52's wound care were completed as ordered and Resident #98's peripherally inserted central catheter (PICC) was removed timely as ordered. This finding affected one (Resident #104) of three residents reviewed for a change in condition, two (Residents #7 and #52) of three residents reviewed for general skin conditions, and one (Resident #98) of one resident reviewed for PICC lines. The facility census was 89.Findings include:1. Review of Resident #104's medical record revealed the resident was admitted on [DATE] with diagnoses including Alzheimer's disease with late onset, dementia in other diseases classified elsewhere and need for assistance with personal care.Review of Resident #104's hospital discharge documentation dated 08/12/24 revealed the resident's code status was Do Not Resuscitate (DNR) Do Not Intubate (DNI).Review of Resident #104's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.Review of Resident #104's Nurse Practitioner (NP) progress note dated 05/07/25 revealed the resident was assessed regarding a recent hospice referral. The family refused to sign the hospice consent.Review of Resident #104's Palliative Care note dated 05/27/25 revealed the resident was being seen today for palliative care visit.Review of Resident #104's NP progress note dated 06/09/25 revealed the staff requested an encounter for weakness and difficulty transferring. The resident was awake, alert and in no acute distress. The resident was calm, cooperating and appeared comfortable. The resident was chronically ill appearing lying back in a broda chair.Review of Resident #104's progress note dated authored by Registered Nurse (RN) #657 dated 06/15/25 at 11:56 P.M. revealed resident noted oxygen saturation of 85 % very sleepy and would respond to name then back to sleep oxygen placed on two liters of oxygen via nasal cannula and a note was left in the physician book.Review of Resident #104's vital signs documented in the electronic health record (EHR) confirmed the resident's oxygen level was 85% on room air, the blood pressure was 100/50, the respirations were 22 breaths per minute, and the temperature was 97 degrees Fahrenheit.Review of Resident #104's progress note dated 06/16/25 at 11:21 A.M. revealed NP #658 was in to assess the resident with a new order to send the resident to the emergency room (ER) for altered mental status and hypoxia. An Attempt to notify the representative without success. Report called to the ER. Review of Resident #104's NP Progress note dated 06/16/25 revealed the staff requested an encounter for a change in condition and hypoxia. The resident resides in a long-term care facility and staff reported the resident had been unable to feed self, very restless, minimal response. The prior night the oxygen level was 85% and two liters of supplemental oxygen were placed. The resident's lips were purple and aroused with repeated stimuli. The resident did not follow commands.Review of Resident #104's progress note dated 06/16/25 at 5:59 P.M. authored by RN #659 revealed she spoke with the ER, and the resident was admitted to the intensive care unit (ICU) for a urinary tract infection (UTI) and altered mental status.Review of Resident #104's Hospital Inpatient Patient Summary report dated 06/19/25 at 2:45 P.M. revealed the admission reason was hyper UTI, confusion and natremia.Review of Resident #104's progress note dated 06/19/25 at 6:39 P.M. revealed the resident was readmitted from the hospital.Review of Resident #104's progress note dated 06/20/25 at 7:29 P.M. revealed the nurse practitioner signed the DNR Comfort Care (DNR CC) form.Interview on 04/14/26 at 2:00 P.M. with NP #658 confirmed she had assessed Resident #104 in the middle of the morning on 06/16/26 and the resident needed to go to the hospital. NP #658 confirmed RN #657 should have called for the resident's change in condition, and she was not aware of the change in condition until the next day. Interview on 04/15/26 at 10:12 A.M. with Regional RN #649 confirmed the nurse should have called (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the NP for Resident #104's change in condition.Interview on 04/15/26 at 11:32 A.M. with Regional RN #649 confirmed no one notified her of the change in condition not addressed.Review of the Guidelines for Provider Notification form updated 06/2023 confirmed immediate notification for the provider included change in condition/mental status, fall with injury requiring further evaluation and treatment, weight changes, abnormal X-ray and PT/INR results. 2. Review of Resident #52's hospital history and physical dated 03/17/26 revealed a left great toe wound was present with no purulence or bloody discharge. Review of Resident #52's Infectious Disease (ID) Consult Notes dated 03/26/26 at 4:44 P.M. digitally signed by Physician #651 revealed the resident had a left great toe gangrenous change. The X-Ray of the left foot revealed extensive vascular calcifications and no acute findings. Review of Resident #52's medical record revealed the resident was admitted on [DATE] (readmitted on [DATE] following a fall) with diagnoses including pneumonia, gangrene of the left great toe and unsteadiness on the feet. Review of Resident #52's progress note dated 03/27/26 at 9:30 P.M. (recorded as a late entry on 03/28/26 at 7:15 A.M.) revealed the resident was admitted from the hospital following a placement of three heart stents. A head-to-toe skin assessment was completed with a skin tear on the right forearm and a recent left big toe removal. Review of Resident #52's History and Physical form dated 03/30/26 authored by the Medical Director (MD) revealed ID recommended workup of the left foot due to concern of possible toe ulceration following recent left great toe removal. The Cat (CT) Scan did not demonstrate osteomyelitis, only swelling. ID recommended four weeks of antibiotics with outpatient follow-up. Review of Resident #52's Diabetic Ulcer Care Plan revealed an intervention dated 03/30/26 to perform current treatment as ordered and observe for effectiveness. Review of Resident #52's Wound Observation History form dated 03/30/26 at 1:44 P.M. revealed the resident had a left great toe wound which measured 2.9 centimeters (cm) length by 3.8 cm width by 0.4 cm depth with moderate exudate with full thickness through the dermis and down to the subcutaneous tissue and muscle with granulation tissue. The surrounding skin was dark purple or rusty discoloration with edema. Review of Resident #52's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #52's physician orders revealed an order dated 04/01/26 (discontinued 04/09/26) to cleanse the left great toe with normal saline, pat dry, apply calcium alginate and silicone super absorbent dressing and change daily; and an order dated 04/09/26 to cleanse the left great toe with normal saline, pat dry, apply xeroform and silicone super absorbent dressing once daily. Review of Resident #52's medication administration records (MARS) and treatment administration records (TARS) from 03/27/26 to 04/15/26 revealed no evidence the left great toe wound treatments were completed on 04/04/26, 04/07/26, and 04/08/26. Review of Resident #52's Wound Observation History dated 04/06/26 at 2:23 P.M. revealed the (continued on next page)

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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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had a left great toe wound which measured 4 cm length by 8.5 cm width and the depth could not be measured. The tissue type was necrotic with thin watery exudate and 10% epithelialization tissue and 70% eschar. The area had an increase and a recommendation referral to vascular along with an antibiotic order and new treatment order. The resident and the resident's spouse were notified. Interview on 04/16/26 at 7:52 A.M. with Regional RN #649 confirmed Resident #52's medical record did not have evidence of wound care to the resident's left great toe on 04/04/26, 04/07/26 or 04/08/26. Interview on 04/16/26 at 11:42 A.M. with the MD revealed Resident #52 did not require treatments to the left great toe upon admission from 03/27/26 to 03/31/26 and treatments were initiated on 04/01/26. The MD confirmed Resident #52's left great toe declined due to the resident's disease process. Telephone interview on 04/16/26 at 2:45 P.M. with Resident #52's wife who revealed she felt care and services were not provided timely for the resident's left toe wound. 3. Review of Resident #7's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including cutaneous abscess of the left lower limb, muscle weakness and major depressive disorder. Review of Resident #7's Surgical Wound Care Plan revealed an intervention dated 02/06/26 to perform current treatment as ordered and observe for effectiveness. Review of Resident #7's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #7's physician orders revealed an order dated 03/13/26 (discontinued 04/14/26) to cleanse the left lower extremity with normal saline, pat dry, apply silver alginate and cover with an abdominal dressing and secure with paper tape every other day and as needed; and an order dated 04/14/26 to cleanse the left lower extremity with normal saline, pat dry, apply silver alginate and cover with an abdominal dressing and secure with paper tape once daily and as needed (from 7:00 A.M. to 3:00 P.M.). Review of Resident #7's MARS and TARS from 03/01/26 to 04/20/26 revealed no evidence wound care to the left lower extremity was completed on 03/27/26, 03/31/26, and 04/14/26 (documented as morning shift nurse did not complete). Review of Resident #7's physician orders revealed an order dated 03/13/26 (discontinued 04/09/26) to cleanse the left upper thigh with normal saline, pat dry, apply silver alginate and cover with an abdominal dressing and secure with paper tape once every other day and as needed; and order dated 04/09/26 to cleanse the left upper thigh with normal saline, pat dry, apply silver alginate, cover with an abdominal dressing and secure with paper tape once daily and as needed (from 7:00 A.M. to 3:00 P.M.). Review of Resident #7's MARS and TARS from 03/01/26 to 04/20/26 revealed no evidence wound care to the left upper thigh was completed on 03/27/26, 03/31/26 and 04/16/26 (documented as morning shift nurse did not complete). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/20/26 at 8:40 A.M. with Regional RN #649 confirmed the above findings. Interview on 04/21/26 at 11:30 A.M. with Resident #7 revealed the resident could not state if the wound care to the left upper thigh or left lower leg was completed as ordered. Review of the Clean Technique Wound Care policy updated 05/01/25 revealed it was the facility's policy to provide wound care to residents using professional standards of practice. 4. Review of the medical record for Resident #98 revealed an admission date of 01/19/26 and discharge date of 02/10/26. Diagnoses included metabolic encephalopathy, chronic diastolic heart failure, peripheral vascular disease, and end stage renal disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #98 had mild cognitive impairment and required extensive assistance for all activities of daily living. Review of the progress note dated 01/21/26 revealed Resident #98 in on intravenous antibiotics via PICC line, tolerating well, and safety measures are maintained. Review of the comprehensive care plan dated 01/23/26 revealed no care plan related to the PICC line. Review of the progress note dated 01/23/26 revealed the nurse spoke with the physician regarding the removal of the PICC line for Resident #98 due to her receiving antibiotics during dialysis treatment. The physician gave an order to remove the PICC line. Resident #98 was notified. Review of the progress note dated 01/24/26 revealed vascular access team in the facility to remove Resident #98's PICC line per order. No attempts were made to remove the PICC line due to it's proximity to the existing dialysis catheter and no documentation from the inserting hospital about the status of the PICC line. The vascular access team recommended the facility reach out to the inserting facility to remove. Resident #98 would need an appointment scheduled. Resident #98 was notified. Review of the orders for Resident #98 revealed an order dated 01/27/26 revealed an order to schedule an appointment for PICC line removal. No other PICC line orders were observed. Review of the progress note dated 02/03/26 revealed the nurse received a call back from the hospital requesting that they fax the order again to remove Resident #98's PICC line. The order was refaxed and they were awaiting a call back. Review of the progress note dated 02/05/26 revealed Resident #98 was requesting to go to the hospital for becoming hypoglycemic during dialysis. Review of the progress note dated 02/05/26 revealed Resident #98 returned from the hospital emergency room and her PICC line was removed there. Interview on 04/20/26 at 10:22 A.M. with Regional Nurse #649 confirmed the order to pull Resident #98's PICC line was placed on 01/23/26. The nurse assessed the PICC line on 01/24/26 and saw a suture intact and notified the facility's access center. They accessed the line on 01/24/26 and could not determine if the line was tunneled and they were concerned due to how close it was to the dialysis access, so they recommended the facility reach out to the inserting facility and schedule a removal. The PICC line was inserted in the interventional radiology department at the local hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No documentation was placed regarding reaching out to that facility until 02/03/26. She confirmed there was no documentation of PICC line care. This deficiency represents non-compliance investigated under Complaint Numbers 2799624, 2795522 and 261336.

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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** Based on record review and interview, the facility failed to ensure Residents #3, #66 and #67's pressure ulcer wound care was completed as ordered and per best practice guidelines. This finding affected three (Residents #3, #66 and #67) of six residents reviewed for pressure ulcers. The facility census was 89.Findings include: 1. Resident #3 was admitted to the facility on [DATE] with diagnoses including chronic cholecystitis, congestive heart failure, high blood pressure, renal insufficiency, diabetes, protein malnutrition, anxiety disorder, depression, atrial fibrillation, and chronic obstructive pulmonary disorder. Review of Resident #3's physician's orders revealed on 12/12/25 and order was written for Expedite (a liquid protein supplement) 30 milliliters (ml) twice a day for wounds. An order written on 03/09/26 to clean sacrum with wound cleanser as needed and on a weekly basis. No other wound healing supplements were ordered. Review of the comprehensive quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #3, dated 01/19/26, revealed the resident was cognitively intact, was always incontinent of bowel and bladder, and had a Stage 4 pressure injury (a severe, full-thickness wound extending to exposed muscle, tendon, or bone) which was present upon admission. Review of the Medication Administration Record (MAR) for April 2026 for Resident #3 revealed no as needed wound cleansing was provided by the facility. Review of the wound notes for Resident #3 by Wound Nurse Practitioner (WNP) #652 revealed the resident had a Stage 4 pressure ulcer to the sacrum with wound onset dated approximately 05/20/25. Review of the wound evaluation dated 04/13/26 revealed the wound progress was considered to be stagnate. WNP #652 chose to use a TV-8 Tiger Tail trial for that reason. No information was provided by the facility regarding what a Tiger Tail trial consisted of. Due to difficulty keeping the dressing intact WNP #652 utilized gentian violet (a liquid applied to cuts, scrapes, and burns to prevent infection), skin prep (a wipe used to increase adhesiveness of a dressing), and stomahesive (a paste and powder designed to protect skin and improve adhesion by filling uneven skin surfaces and absorbing moisture) to keep the dressing in place. The dressing was to be changed weekly by WNP #652. Review of the wound notes from 03/23/26 through 04/13/26 revealed the wound was stagnate but was noted by WNP #652 to be improved and healing each week. Observation on 04/20/26 at 7:39 A.M. with WNP #652 of Resident #3's stage four sacrum pressure ulcer wound care revealed the resident did not have a dressing in place at the time of the observation. WNP #652 assessed Resident #3's stage four sacrum pressure wound which measured 1.6 centimeters (cm) in length by 0.5 cm in width and 0.3 cm depth. Interview on 04/20/26 at 7:41 A.M. with WNP #652 confirmed Resident #3's sacrum pressure ulcer wound care was completed weekly on a Monday. When questioned, she revealed the dressing usually did not last all week due to showers etc. and there were orders to replace the dressing. WNP #652 confirmed she was unsure how long the dressing had been off the resident's sacrum pressure ulcer wound and the staff usually leave the resident's wound care for her to complete once weekly since the resident was on a clinical wound trial. Interview on 04/20/26 at 7:52 A.M. with Resident #3 revealed she had a shower on 04/14/26. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with WNP #652 on 04/20/26 at 11:46 A.M. revealed Resident #3's dressing should be in place for seven days. Each week she removes the dressing and takes it off and applies a new one. The resident is currently on week nine of a skin substitute called [NAME] (Cellular, Acellular, and Matrix-like Products ([NAME]) used to treat chronic, hard to heal wounds by promoting tissue regeneration and remodeling. The wound looked good today. The resident does not need a dressing as the wound is not that deep. WNP #652 said the resident's dressing did come off this week however when she had a shower. WNP #652 said until today she had not written an order for what the staff should do if the dressing comes off before her visit. She wrote an order today to cleanse the wound with wound cleanser and apply a foam dressing. WNP #652 confirmed staff did not notify her the dressing had come off and she did not know when it came off. Review of the facility's Pressure Injuries: Assessment, Prevention & Treatment policy, last revised 05/01/25, revealed it was the facility's policy to identify residents at risk for developing pressure injuries and provide care for existing pressure injuries. Any resident with wounds will be referred to the dietician. Vitamins, mineral and protein supplements should be used in accordance with physician orders. 2. Review of Resident #66's medical record revealed the resident was admitted on [DATE] with diagnoses including paraplegia, pressure ulcer of sacral region stage 4 and generalized anxiety disorder. Review of Resident #66's Pressure Ulcer Injury Care Plan revealed an intervention dated 06/20/23 to perform current treatment as ordered and observe treatment for effectiveness. Review of Resident #66's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #66's physician orders revealed an order dated 02/16/26 (discontinued 03/10/26) to cleanse the sacrum with normal saline, pat dry, apply a small cut to size piece of hydrofera blue, and cover with a composite dressing every Monday, Wednesday and Friday; an order dated 03/10/26 (discontinued 03/31/26) to cleanse the sacrum with normal saline, pat dry, apply hydroconductive dressing, silicone super absorbent dressing daily; an order dated 03/31/26 (discontinued 04/09/26) to cleanse the sacrum with normal saline, pat dry, apply collagen, silicone super absorbent dressing daily; an order dated 04/09/26 to cleanse the sacrum with normal saline, pat dry, apply collagen, silicone super absorbent dressing daily. Review of Resident #66's Observation History form dated 04/20/26 at 3:50 P.M. revealed the resident had a Stage 4 sacrum pressure ulcer which measured 0.4 centimeters (cm) length by 1.1 cm width by 0.2 cm depth. Review of Resident #66's medication administration records (MARS) and treatment administration records (TARS) from 03/01/26 to 04/16/26 revealed no evidence treatments were completed on 03/13/26, 03/27/26 and 04/04/26. Interview on 04/15/26 at 7:41 A.M. with Regional Registered Nurse (RN) #649 confirmed Resident #66's wound care treatments were not completed as ordered. 3. Review of Resident #67's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic kidney disease stage 4, diabetes and hypothyroidism. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #67's Pressure Ulcer/Injury Care Plan revealed an intervention dated 03/30/26 to perform current treatment as ordered and observe treatment for effectiveness. Review of Resident #67's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #67's physician orders revealed an order dated 03/31/26 to cleanse the left upper buttock with normal saline, pat dry, apply medihoney and calcium alginate, cover with a dry dressing and change daily. Review of Resident #67's Observation History form dated 04/13/26 at 4:30 P.M. revealed the resident had an unstageable (with slough and/or eschar) left upper, inner buttock pressure wound which measured 3.3 cm length by 2.6 cm width and the depth could not be measured. Review of Resident #67's MARS and TARS from 04/01/26 to 04/14/26 revealed no evidence wound care was completed on 04/01/26, 04/04/26, 04/06/26, 04/07/26, 04/09/26, 04/10/26, 04/12/26 and 04/13/26. Interview on 04/15/26 at 9:10 A.M. with Regional RN #649 confirmed the above findings. Review of the Pressure Injuries: Assessment, Prevention and Treatment policy updated 05/01/25 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 2727070.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to provide safe transfer assistance utilizing a mechanical lift device for Resident #61. This affected one resident (#61) out of seven reviewed for accident hazards. The facility census was 89. Findings include: Review of the medical record for Resident #61 revealed an admission date of 10/07/24 with diagnoses including end stage renal disease, abnormalities of gait and mobility, reduced mobility, rheumatoid arthritis, acquired absence of left leg below knee, repeated falls, and history of transient ischemic attack and cerebral infarction. Review of the care plan dated 10/08/24 revealed Resident #61 had impaired ability to perform or participate in activities of daily living (ADL) care related to left below knee amputation, diabetes mellitus, tremors, use of assistive devices, dialysis, impaired range of motion of the left lower extremity, and medical co-morbidities. Interventions included provide assistance with ADL care and mobility as needed and anticipate resident needs as able implemented 10/08/24. Review of the five day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment indicated Resident #61 was dependent for chair/bed-to-chair transfers. Review of the physician's orders for Resident #61 identified orders for bed to chair transfers to be completed with a mechanical lift with assistance of two staff effective 01/27/26. On 04/13/26 at 3:41 P.M., an observation revealed Certified Nursing Assistant (CNA) #613 enter Resident #61's room with a mechanical lift device and no other aide was observed entering or exiting the room. On 04/13/26 at 3:46 P.M., an observation of Resident #61's room revealed CNA #613 was operating the mechanical lift device alone to lower Resident #61 into bed. There were no other staff members present in the room at this time. On 04/13/26 at 3:48 P.M., an interview with Regional Registered Nurse (RN) #649 confirmed CNA #613 was in Resident #61's room with the mechanical lift device and there were no other staff in the room. On 04/13/26 at 3:50 P.M., an interview with CNA #613 confirmed she transferred Resident #61 from the wheelchair to the bed using a mechanical lift device. CNA #613 claimed another CNA (#620) was assisting with the transfer but left to go back to the Assisted Living hall. On 04/13/26 at 3:57 P.M., an interview with CNA #620 said she did not help CNA #613 transfer Resident #61 because she had to go back to the Assisted Living unit. CNA #620 further stated CNA #613 was the only aide assigned to Resident #61's hall. On 04/14/26 at 8:01 A.M., an interview with Resident #26 stated staff operated mechanical lifts with only staff member to transfer her. On 04/14/26 at 9:54 A.M., an interview with Resident #61 stated staff always transferred her with just one person operating the lift because there was only ever one aide assigned to the hall. Review of the facility policy titled Hoyer Lift, dated 05/01/25, revealed two staff members must be present when using the lift device. This deficiency represents non-compliance investigated under Complaint Numbers 2742677 and 2690512.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents on dialysis received ongoing assessment and monitoring to ensure health status and reduce complication of dialysis care. This finding affected three (Residents #26, #67, and #85) of five residents reviewed for dialysis. The facility census was 89.Findings include:1. Review of the medical record for Resident #26 revealed an admission date of 03/29/25 with diagnoses including congestive heart failure, type two diabetes mellitus, hypertension, and end stage renal disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had no cognitive impairment and received dialysis treatments. Review of the physician's orders for Resident #26 identified orders for dialysis every Monday, Wednesday and Friday at 5:30 A.M. effective 04/06/26, complete the pre-dialysis observation and vital signs on dialysis days at 4:30 A.M. effective 04/06/26, and completed the post-dialysis observation and vital signs on dialysis days at 12:30 P.M. effective 04/06/26. Review of the pre- and post-dialysis assessments for Resident #26 from January 2026 through April 2026 revealed the following: On 01/02/26, the pre-dialysis assessment was missing the weight. On 01/05/26, the pre-dialysis assessment was missing the weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 01/07/26, the pre-dialysis assessment was missing the weight. On 01/09/26, the pre-dialysis assessment was missing the pulse, temperature, respirations, pulse ox, and weight. On 01/12/26, the pre-dialysis assessment was missing the weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 01/15/26, there was no pre-dialysis assessment or post-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 01/15/26. On 01/16/26, the pre-dialysis assessment was missing the weight and there was no post-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 01/16/26. On 01/19/26, the pre-dialysis assessment was missing the weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 01/21/26, the pre-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox, and there was no post-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 01/21/26. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/26, the pre-dialysis assessment was missing the weight. On 01/26/26, the pre-dialysis assessment was missing the weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 01/28/26, the pre-dialysis assessment was missing the weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 01/30/26, the pre-dialysis assessment was missing the weight, and the post-dialysis assessment was missing the blood pressure, pulse, temperature, respirations, and pulse ox. On 02/02/26, the pre-dialysis assessment was missing the weight. On 02/04/26, the pre-dialysis assessment was missing the pulse, temperature, respirations, pulse ox, and weight. On 02/06/26, the pre-dialysis assessment was missing the temperature, respirations, pulse ox, and weight. On 02/09/26, the pre-dialysis assessment was missing the temperature, respirations, pulse ox, and weight. On 02/11/26, the pre-dialysis assessment was missing the temperature, respirations, pulse ox, and weight. On 02/13/26, the pre-dialysis assessment was missing the weight. On 02/16/26, the pre-dialysis assessment was missing the weight. On 02/18/26, the pre-dialysis assessment was missing the weight, and there was no post-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 02/18/26. On 02/23/26, there was no pre-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 02/23/26. On 02/25/26, there was no pre-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 02/25/26. On 02/27/26, the pre-dialysis assessment was missing the weight. On 03/02/26, there was no pre-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 03/02/26. On 03/04/26, the pre-dialysis assessment was missing the blood pressure and weight, and there was no post-dialysis assessment in the medical record. The dialysis communication form sent from the (continued on next page)

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	365482	A. Building B. Wing	04/21/2026

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

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis center indicated Resident #26 received dialysis treatment on 03/04/26. On 03/06/26, the pre-dialysis assessment was missing the weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 03/09/26, the pre-dialysis assessment was missing the weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 03/11/26, the pre-dialysis assessment was missing the blood pressure, pulse, temperature, pulse ox, and weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 03/13/26, the pre-dialysis assessment was missing the weight. On 03/14/26, there was no pre-dialysis assessment or post-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 03/14/26. On 03/16/26, the pre-dialysis assessment was missing the weight. On 03/18/26, the pre-dialysis assessment was missing the respirations, pulse ox, and weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 03/20/26, the pre-dialysis assessment was missing the weight. On 03/23/26, the pre-dialysis assessment was missing the temperature, respirations, pulse ox, and weight. On 03/25/26, the pre-dialysis assessment was missing the weight, and the post-dialysis assessment was missing the pulse, temperature, respirations, and pulse ox. On 03/27/26, the pre-dialysis assessment was missing the weight, and there was no post-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 03/27/26. On 03/30/26, there was no pre-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 03/30/26. On 04/06/26, there was no pre-dialysis assessment or post-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 04/06/26. On 04/08/26, the pre-dialysis assessment was missing the weight, and there was no post-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 received dialysis treatment on 04/08/26. On 04/10/26, there was no pre-dialysis assessment or post-dialysis assessment in the medical record. The dialysis communication form sent from the dialysis center indicated Resident #26 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received dialysis treatment on 04/10/26. On 04/17/26 at 1:15 P.M., an interview with Regional Registered Nurse (RN) #649 verified dialysis assessments were not completed as ordered. Regional RN #649 further stated the facility got cited on every survey for dialysis assessments because they had such a large population of residents receiving dialysis treatments. Review of the facility policy titled Dialysis Policy, dated 05/01/25, revealed residents were to receive interdisciplinary monitoring to ensure safety and the facility was to complete pre and post-dialysis assessments. 2. Review of the medical record for Resident #85 revealed they were admitted to the facility on [DATE] with diagnoses that included stroke, hemiplegia (paralysis of one side of the body), hemiparesis (weakness on one side of the body), end stage renal disease (ESRD), need for assistance with personal care, muscle weakness, and reduced mobility. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #85 was cognitively impaired, had behaviors not directed towards others, did not reject care, required maximal assistance for most activities of daily living, was dependent for transferring, and required dialysis. Review of the care plan revealed Resident #85 had an alteration in renal function related to ESRD and dialysis dated 01/27/26 with a goal to not have dialysis related complications and the facility and dialysis center were to coordinate care. Interventions included monitoring the dialysis access site, observe for signs and symptoms of fluid retention which included shortness of breath and high blood pressure, obtain vital signs as ordered, and the facility was to communicate any concerns to the dialysis center. Review of the physician orders revealed orders for dialysis every Monday, Wednesday, and Friday dated 01/26/26; pre-dialysis observation and vital signs were to be completed on dialysis days dated 03/23/26; and post-dialysis observation and vital signs were to be completed on dialysis days dated 01/26/26. Review of the dialysis communication sheets from 03/02/26 to 04/15/26 revealed Resident #85 received dialysis 03/02/26, 03/04/26, 03/06/26, 03/09/26, 03/11/26, 03/14/26, 03/16/26, 03/18/26, 03/20/26, 03/23/26, 03/25/26, 03/27/26, 03/30/26, 04/03/26, 04/06/26, 04/08/26, 04/10/26, and 04/13/26. Review of the pre and post-dialysis assessments from 03/02/26 to 04/13/26 revealed the following: the post-dialysis assessment on 03/02/26 was absent of all vital sign documentation except blood pressure; the post-dialysis assessment on 03/04/26 was absent of all vital sign documentation except blood pressure; the post-dialysis assessment on 03/06/26 was absent of all vital sign documentation except blood pressure; the pre-dialysis assessment on 03/11/26 was absent of all vital sign documentation except blood pressure; the post-dialysis assessment on 03/11/26 was absent of all vital sign documentation except blood pressure; on 03/13/26 a post-dialysis assessment was not completed; the post-dialysis assessment on 03/25/26 was absent of all vital sign documentation except blood pressure; on 03/27/26 a pre-dialysis assessment was not completed; the post-dialysis assessment on 04/03/26 was absent of all vital sign documentation except for blood pressure; the post-dialysis assessment on 04/06/26 was absent of all vital sign documentation except blood pressure; on 04/08/26 a post-dialysis assessment was not completed; on 04/10/26 a (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pre-dialysis assessment was not completed; on 04/10/26 the post-dialysis assessment was absent of vital sign documentation and a note to see the Medication Administration Record (MAR) for vital signs; and the post-dialysis assessment on 04/13/26 was absent of all vital sign documentation except blood pressure. Review of the progress notes from 03/02/26 to 04/15/26 revealed the absence of documentation related to incomplete dialysis assessments, missing dialysis assessments, or resident refusal of assessments or vital signs. Review of the MAR from 03/02/26 to 03/31/26 revealed all post-dialysis observations were documented as completed. Review of the MAR from 04/01/26 to 04/14/26 revealed all post-dialysis assessments were documented as completed. An interview on 04/15/26 at 10:12 A.M. with Regional Registered Nurse (RN) #649 verified the above findings. Review of the dialysis contract dated 10/19/18 revealed the facility was to provide the dialysis center with any information related to a change in condition, any information that would facilitate coordination of care, and the facility was responsible to ensure the resident was medically stable for transportation to the dialysis center. Review of the facility policy titled Dialysis Policy, dated 05/01/25 revealed residents were to receive interdisciplinary monitoring to ensure safety and the facility was to complete pre and post-dialysis assessments. 3. Review of Resident #67's medical record revealed the resident had chronic kidney disease stage 4, diabetes and hypothyroidism. Review of Resident #67's Alteration in Renal Function Care Plan dated 03/26/26 revealed the resident was on hemodialysis. Review of Resident #67's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #67's physician orders revealed an order dated 03/27/26 for dialysis every Tuesday, Thursday and Saturday with a chair time of 10:15 A.M.; an order dated 03/27/26 to complete post-dialysis observation on dialysis days on Tuesday, Thursday and Saturday; and an order dated 03/27/26 to complete pre-dialysis observation and vital signs on dialysis days once a day on Tuesday, Thursday and Saturday; and an order dated 03/26/26 for daily weights once a day. Review of the hemodialysis assessments confirmed a pre-assessment was completed on 04/02/26 at 3:11 P.M.; post assessment on 04/02/26 at 3:12 P.M.; pre assessment on 04/04/26 at 9:06 A.M.; no post assessment for 04/04/26; pre assessment on 04/07/26 at 2:37 P.M.; post assessment on 04/07/26 at 2:38 P.M.; pre assessment on 04/09/26 at 2:36 P.M.; post assessment on 04/09/26 at 2:40 P.M.; pre assessment on 04/14/26 at 3:03 P.M.; and post assessment on 04/14/26 at 3:04 P.M. Review of Resident #67's dialysis assessments revealed no evidence that a post hemodialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment was completed on 04/04/26. Review of Resident #67's medical record from 04/01/26 to 04/14/26 revealed no evidence daily weights were completed on 04/01/26, 04/03/26, 04/04/26, 04/08/26, 04/10/26, 04/11/26, 04/12/26 and 04/13/26. Interview on 04/15/26 at 9:15 A.M. with Regional Registered Nurse (RN) #649 confirmed the above findings. Review of the Dialysis Policy updated 05/01/25 revealed it was the policy of the facility that all residents utilize renal dialysis receive comprehensive interdisciplinary monitoring to ensure resident safety and support of dialysis services. This deficiency represents non-compliance investigated under Complaint Number 2637021.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, record review, interview, and review of facility policy, the facility failed to provide sufficient nursing staff to meet resident needs including answering call lights in a timely manner and operating mechanical lift devices in a safe manner. This affected three residents (#17, #40, and #61) and had the potential to affect all 89 residents in the facility. Findings include:On 04/13/26 at 10:44 A.M., an interview with Resident #39 stated there was not enough staff on first and second shifts, and call lights took a while to answer. On 04/13/26 from 11:06 A.M. through 11:32 A.M., observation and interview revealed Resident #40 was on airborne precautions for Covid with personal protective equipment (PPE) located outside the resident's closed door. At 11:06 A.M. Resident #40 activated her call light. The call light remained on at 11:11 A.M. Facility staff were observed going up and down hall past the resident's room while the light was on including Regional Registered Nurses (RRN) #648 and #649. The Assistant Director of Nursing also went up and down the hall without stopping. Resident #40's call light remained on at 11:17 A.M., 11:21 A.M., 11:25 A.M., and 11:30 A.M. At 11:32 A.M. this surveyor asked RRN #649 why the resident's call light had not been responded to since 11:06 A.M. RRN #649 replied she was just going to check on the resident now. RRN #648 then told RRN #649 he would go in and check on the resident, put on the required PPE and entered the room. On 04/13/26 at 11:12 A.M., an interview with Resident #2 stated care was rushed and it took an hour to answer call lights. On 04/13/26 at 11:27 A.M., an interview with Resident #13 stated it took a half hour to answer his call light and an hour total to address his need. Resident #13 stated this primarily happened on night shift. On 04/13/26 at 1:29 P.M., an interview with Resident #22 stated there was not enough staff, call lights took an hour to answer, and medications were administered late. On 04/13/26 at 3:07 P.M., an interview with Resident #110 stated staff did not come when the call light was pressed, sometimes taking more than two hours, and it happened more on night shift. On 04/13/26 at 3:27 P.M., an interview with Resident #7 stated there was not enough staff and she had problems getting her evening medications timely. On 04/13/26 at 3:41 P.M., an observation revealed Certified Nursing Assistant (CNA) #613 enter Resident #61's room with a mechanical lift device and no other aide was observed entering or exiting the room. On 04/13/26 at 3:46 P.M., an observation of Resident #61's room revealed CNA #613 was operating the mechanical lift device alone to lower Resident #61 into bed. There were no other staff members present in the room at this time. On 04/13/26 at 3:48 P.M., an interview with Regional Registered Nurse (RN) #649 confirmed CNA #613 was in Resident #61's room with the mechanical lift device and there were no other staff in the room. On 04/13/26 at 3:50 P.M., an interview with CNA #613 confirmed she transferred Resident #61 from the wheelchair to the bed using a mechanical lift device. CNA #613 claimed another CNA (#620) was assisting with the transfer but left to go back to the Assisted Living hall. On 04/13/26 at 3:50 P.M., an interview with Resident #85 stated call lights took a while to be answered. On 04/13/26 at 3:57 P.M., an interview with CNA #620 said she did not help CNA #613 transfer Resident #61 because she had to go back to the Assisted Living unit. CNA #620 further stated CNA #613 was the only aide assigned to Resident #61's hall. On 04/14/26 at 8:01 A.M., an interview with Resident #26 stated staff operated mechanical lifts with only staff member to transfer her. On 04/14/26 at 9:54 A.M., an interview with Resident #61 stated staff always transferred her with just one person operating the lift because there was only ever one aide assigned to the hall. On 04/14/26 at 10:25 A.M., an interview with Resident #1 stated he had staffing concerns. On 04/14/26 at 11:21 A.M., an interview with Resident #40 stated it took over 30 minutes to answer her call light on 04/13/26 because she was on isolation for COVID-19. On 04/16/26 at 9:03 A.M., an observation revealed Resident #17's call light was activated. At 9:04 A.M., Medical Records Coordinator #503 entered Resident #17's room, Resident #17 said she needed changed, and Medical Records Coordinator #503 deactivated Resident #17's call light at that time. At 9:12 A.M., Resident #17 activated her call light again. At 9:16 A.M., Medical (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Records Coordinator #503 entered Resident #17's room, Resident #17 said she still needed to be changed, and Medical Records Coordinator #503 deactivated Resident #17's call light at that time. No other staff were observed entering Resident #17's room from 9:16 A.M. to 9:34 A.M. On 04/16/26 at 9:34 A.M., an interview with Resident #17 confirmed nobody had come to change her yet. On 04/16/26 at 9:34 A.M., an interview with Certified Medication Aide (CMA) #529 stated she was unaware Resident #17 needed changed. On 04/16/26 at 9:37 A.M., observation revealed CMA #529 and Certified Nursing Assistant (CNA) #544 entered Resident #17's room to perform incontinence care, approximately 34 minutes after Resident #17 initially requested assistance. On 04/16/26 at 9:45 A.M., an interview with Regional Registered Nurse (RN) #649 stated it was not typically policy to deactivate the call light without addressing the need. She further stated if someone who was unable to provide the requested care answered the call light, they could turn the call light off and go get someone who could provide the care. During the Resident Council meeting on 04/20/26 at 1:01 P.M. with Residents #40, #43, #66, and #90 revealed Residents #40, #66, and #90 all stated call light response time by staff was always a long wait. They felt the facility put too much on the staff to handle and to large an assignment. Resident #40 said when she had Covid-19 recently she felt like nobody wanted to take the time to put on a gown and come into her room to answer her call light. This deficiency represents non-compliance investigated under Complaint Numbers 2690512 and 2637021.

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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** Based on observation, record review and interview, the facility failed to ensure Resident #12 was free from significant medication error. This finding affected one (Resident #12) of six residents observed for medication administration. The facility census was 89.Findings include: Review of Resident #12's medical record revealed the resident was admitted on [DATE] with diagnoses including muscle weakness, need for assistance with personal care and chronic kidney disease stage 4.Review of Resident #12's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] the resident exhibited intact cognition.Review of Resident #12's physician orders revealed an order dated 04/11/26 for Buspirone 10 milligrams (mg) three times a day (due at 7:00 A.M. to 11:00 A.M., 1:00 P.M. to 2:30 P.M. and 6:30 P.M. to 10:30 P.M.; Ferrous Sulfate 325 mg twice daily with meals (due from 7:00 A.M. to 11:00 A.M. and 6:30 P.M. to 10:30 P.M.; Humalog KwikPen insulin 12 units subcutaneous with breakfast once a day at 7:00 A.M.; Lactulose solution 10 grams/15 ml twice a day (9:00 A.M. to 9:30 A.M. and 5:00 P.M. to 5:30 P.M.), Metoprolol Succinate tablet 150 mg (hold for systolic blood pressure less than 90 or heartrate less than 55) twice daily (from 7:00 A.M. to 11:00 A.M. and 6:30 P.M. to 10:30 P.M.); Xifaxan 550 mg twice daily (due 7:00 A.M. to 11:00 A.M. and 6:30 P.M. to 10:30 P.M.), and an order dated 04/14/26 for dialysis every Monday, Wednesday and Friday at 12:30 P.M. The physician orders indicated the blood sugars were to be obtained for breakfast and dinner meals.Review of Resident #12's medication administration records (MARS) and treatment administration records (TARS) on 04/13/26 revealed no evidence a blood sugar was obtained for the breakfast or dinner meals.Review of Resident #12's Nurse Practitioner (NP) Progress note dated 04/07/26 revealed to send blood sugars to endocrinology.Observation on 04/13/26 at 9:26 A.M. revealed Resident #12 was just coming back from dialysis. The resident was observed on a transportation cart in the resident's room. Interview with Resident #12 at the time of the observation revealed she was waiting on staff to transfer her from the cart to bed using a Hoyer mechanical lift.Observation on 04/13/26 at 10:30 A.M. with Licensed Practical Nurse (LPN) #553 revealed the nurse was administering medications to residents on the 100-hall. LPN #553 confirmed Resident #12 returned to the facility around 9:30 A.M. and had breakfast at that time but she had been unable to administer the resident's medications when due because she fell behind.Interview on 04/13/26 at 11:22 A.M. with Resident #12 revealed there were not enough staff, and her medications were consistently administered late. Resident #12 confirmed she had not received her morning medications on this date. Resident #12 confirmed she had her breakfast meal, and she did not receive her insulin as ordered.Interview on 04/13/26 at 12:15 P.M. with Regional Registered Nurse (RN) #649 confirmed LPN #553 had not administered Resident #12's scheduled medications including her insulin in a timely manner. Regional RN #649 confirmed she talked to the NP and adjusted the resident's medications due to the resident's medications not administered timely including the resident's insulin medication.Interview on 04/13/26 at 1:33 A.M. with Regional RN #649 confirmed Resident #12's blood sugars were to be obtained prior to the breakfast and dinner meals (no lunch meal). Regional RN #649 also confirmed Resident #12's blood sugar was not obtained per the MARS and TARS on 04/13/26 for the breakfast or dinner meal.Review of the Medication Administration Policy dated 05/2020 revealed medications were administered as prescribed in accordance with good nursing principles and practices and only by people legally authorized to do so.This deficiency represents non-compliance investigated under Complaint Numbers 2793933 and 2690512.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and interview, the facility failed to maintain complete and accurate documentation in the medical record for all residents. This affected five residents (#2, #8, #26, #57, and #86) and had the potential to affect all 89 residents in the facility. Findings include: 1. Review of the medical record for Resident #26 revealed an admission date of 03/29/25 with diagnoses including congestive heart failure, type two diabetes mellitus, hypertension, and end stage renal disease. Review of the physician's orders for Resident #26 revealed there were no active dietary orders in place. The previous dietary order for a renal diet gluten free was discontinued on 04/01/26. Review of the nutritional assessment dated [DATE] revealed Resident #26 needed a diet order added to the electronic medical record. Review of the dietary progress note dated 04/11/26 at 11:13 A.M. revealed Resident #26 did not have a diet order in the electronic medical record and the previous diet was renal diet gluten free with regular texture and thin liquids. On 04/17/26 at 9:18 A.M., an interview with Regional Registered Nurse (RN) #649 verified Resident #26 did not have a physician's order for dietary restrictions. Regional RN #649 further clarified that the facility was changing the wording of their renal diets and when Resident #26's was discontinued, they must of missed reactivating it with the new wording. 2. Review of the medical record for Resident #2 revealed they were admitted to the facility on [DATE] with diagnoses that included stroke, hemiplegia (paralysis on one side of the body), hemiplegia (weakness on one side of the body), need for assistance with personal care, hypertension, psychotic disorder with delusions, and atrial fibrillation (an abnormal heart rhythm). Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was cognitively impaired, did not reject care, was dependent on staff for activities of daily living, was frequently incontinent of urine, was always incontinent of bowel, and utilized a feeding tube. Review of the care plan revealed Resident #2 had cardiac impairment related to atrial fibrillation, high blood pressure, and stroke dated 03/03/26 with a goal to be free from cardiac complications. Interventions included administering medications as ordered, observing elevated vital signs, and obtaining vital signs as ordered and as needed. Resident #2 had alteration in comfort related to reduced mobility dated 03/03/26 with a goal to verbalize comfort with interventions that included administering pain medications as needed, observing for effectiveness, and observing for breakthrough pain. Review of the physician orders revealed the following: vital signs every shift dated 02/20/26; Diltiazem (a medication to treat high blood pressure) 90 milligrams (mg) every six hours by gastric tube dated 02/24/26 and assess pain every shift dated 02/20/26. Review of the MAR from 03/01/26 to 03/31/26 revealed the following: absence of vital sign documentation for night shit on 03/12/26; the absence of vital sign documentation for day shift on 03/19/26; the absence of vital sign documentation for day shift and evening shift on 03/21/26; the (continued on next page)

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	365482	A. Building B. Wing	04/21/2026

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	absence of vital sign documentation for evenings and night shift on 03/22/26 with a comment that noted previous shift; the absence of vital sign documentation on evening and night shift on 03/23/26; the absence of vital sign documentation on 03/31/26 with a dash as a comment; the absence of a pain assessment on evening shift 03/18/26, the absence of a pain assessment on day shift 03/21/26; and the absence of a pain assessment on evening and night shift on 03/23/26. Blood pressure was not documented prior to all doses of diltiazem administration on 03/01/26, 03/02/26, 03/03/26, 03/04/26, 03/05/26, 03/06/36, 03/07/26, 03/08/26, 03/09/26, 03/10/26, 03/11/26, 03/12/26, 03/13/26, 03/14/26, 03/15/25, 03/16/26, 03/17/26, and 03/18/26. Review of the MAR from 04/01/26 to 04/15/26 revealed the following: pain was not assessed on 04/08/26 for evening shift, pain was not assessed on 04/09/26 for night shit, the absence of vital sign documentation for dayshift on 04/07/26, the absence of vital sign documentation on evening shift for 04/08/26, the absence of vital sign documentation on night shift for 04/09/26, and the absence of vital sign documentation on evening shift for 04/10/26. An interview on 04/15/26 at 10:20 A.M. with Regional Registered Nurse (RN) # 649 verified the above findings. Review of the facility policy titled Change in the Residents Condition or Status, dated 05/01/25 revealed the nurse would monitor and notify the medical team when there was a change in condition and the nurse would record information in the medical record. Review of the facility policy titled Pain Assessment and Management, dated 05/01/25 revealed the facility would assess, evaluate, and treat pain. 3. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] and was discharged on 04/08/26, diagnoses included pancreatic cancer, liver cancer, spinal cancer, dementia, stroke, repeated falls, and heart disease. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #8 was cognitively intact, did not reject care, required moderate to maximal assistance for activities of daily living, received medication for pain, had constant pain, had a history of falling, received antianxiety medications, received opioids, and received anti-seizure medication. Review of the care plan revealed Resident #8 had pain related to metastatic cancer dated 01/28/26 with a goal to verbalize comfort. Interventions included administering pain medications, observing effectiveness, and observing breakthrough pain. Review of the physician orders revealed an order to assess pain every shift dated 01/14/26. Review of the MAR from 03/01/26 to 03/31/26 revealed the absence of pain assessment documentation on 03/05/26 night shift, 03/11/26 day shift, 03/14/26 night shift, 03/16/26 night shift, 03/19/26 night shift, 03/21/26 evening shift, 03/22/26 night shift, 03/26/26 evening shift, 03/27/26 night shift, and 03/29/26 evening shift. Review of the MAR from 04/01/26 to 04/08/26 revealed the absence of pain assessment on 04/02/26 night shift. An interview on 04/21/26 at 12:45 P.M. with Regional RN #649 verified the above findings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Change in the Residents Condition or Status, dated 05/01/25 revealed the nurse would monitor and notify the medical team when there was a change in condition and the nurse would record information in the medical record. Review of the facility policy titled Pain Assessment and Management, dated 05/01/25 revealed the facility would assess, evaluate, and treat pain. 4. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE] with diagnoses that included kidney infection, heart disease, abnormalities of gait and mobility, malnutrition, and low back pain. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #57 was cognitively intact, was incontinent of bowel and bladder, had a pressure reduction device for her bed, and was dependent on staff for toileting, bathing, and transferring. Review of the care plan revealed Resident #57 was at risk of skin breakdown due to impaired mobility and a history of impaired skin integrity dated 08/08/25 with a goal she would not develop skin breakdown. Interventions included observing for signs of skin breakdown and using an air mattress. Review of the physician orders revealed an order for a low air loss mattress and to check placement and function every shift dated 12/18/25 and an order to wash skin folds with mild soap and water, pat dry, and apply antifungal cream three times a day dated 03/16/26. Review of the MAR from 03/01/26 to 03/31/26 revealed the absence of documentation that the low air loss mattress was checked for placement and function from 03/02/26 night shift through all shifts on 03/31/26. Review of the MAR from 04/01/26 to 04/15/26 revealed the absence of any documentation the low air loss mattress was checked for function. Review of the MAR from 04/01/26 to 04/15/26 revealed the absence of documentation skin fold care was performed on 04/04/26 evening shift, 04/04/26 night shift, 04/05/26 evening shift, 04/09/26 night shift, and 04/10/26 evening shift. An interview on 04/13/26 at 10:11 A.M. with Resident #86 revealed he did not have concerns with symptom monitoring or nursing care. An observation on 04/13/26 at 12:12 P.M. revealed Resident #57's bed had a low air loss mattress that Resident #57 was laying on. An interview on 04/15/26 at 3:31 P.M. with Regional RN #649 verified the above findings. An interview on 04/21/26 at 11:13 A.M. with Licensed Practical Nurse (LPN) #517 revealed air mattresses were checked for function and would be documented in the treatment section of the MAR. Review of the facility policy titled Change in the Residents Condition or Status, dated 05/01/25 revealed the nurse would monitor and notify the medical team when there was a change in condition and the nurse would record information in the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the medical record for Resident #86 revealed they were admitted to the facility on [DATE] with re-entry on 06/28/24 with diagnoses that included respiratory failure, chronic obstructive pulmonary disease (lung disease), peripheral vascular disease, arthritis, heart disease, chronic pain, and reduced mobility. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #86 was cognitively intact, had verbal behaviors, rejected care, required set up assistance to supervision for most activities of daily living, and had shortness of breath with exertion. Review of the care plan revealed Resident #86 had cardiac impairment related to heart disease and congestive heart failure dated 07/12/23. Interventions included observing for swelling to lower extremities, observing for shortness of breath, observing for chest pain, and monitor for elevated blood pressure, pulse, or respiration. Review of the physician orders revealed an order to monitor for signs of worsening heart failure dated 06/29/26. Review of the MAR from 03/01/26 to 03/31/26 revealed the absence of heart failure monitoring documentation on 03/02/26 night shift and on 03/09/26 evening shift. Review of the MAR from 04/01/26 to 04/15/26 revealed the absence of heart failure monitoring documentation on 04/04/26 evening shift and night shift, and 04/05/26 evening shift, 04/09/26 night shift. Review of the progress notes from 03/02/26 to 04/15/26 revealed the absence of documentation that Resident #86 refused heart failure monitoring. An interview on 04/13/26 at 10:11 A.M. with Resident #86 revealed he did not have concerns with symptom monitoring or nursing care. An interview on 04/21/26 at 8:50 A.M. with Regional RN #649 verified the above findings. Review of the facility policy titled Change in the Residents Condition or Status, dated 05/01/25 revealed the nurse would monitor and notify the medical team when there was a change in condition and the nurse would record information in the medical record. This deficiency represents non-compliance investigated under Complaint Number 2637021.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to ensure staff followed infection control protocols for residents on contact isolation and droplet isolation. This affected three residents (#12, #17, and #40) out of five reviewed for infection control. The facility census was 89. Findings include: 1. Review of the medical record for Resident #12 revealed an admission date of 08/23/25 with diagnoses including history of urinary tract infections, type two diabetes mellitus, end stage renal disease, congestive heart failure, and need for assistance with personal care. Review of the physician's orders for Resident #12 identified orders for contact transmission based precautions effective 04/11/26. Review of the progress note dated 04/11/26 at 3:20 P.M. revealed Resident #12 had returned from the hospital this day and was on contact isolation precautions due to a urinary tract infection with the presence of Extended-Spectrum Beta-Lactamase (ESBL), which are enzymes produced by bacteria that are resistant to many standard antibiotics. Review of the care plan dated 03/18/26 revealed Resident #12 had recurrent urinary tract infections. Interventions included staff to maintain transmission based precautions as ordered. On 04/13/26 at 11:31 A.M., an observation revealed Nurse Aide in Training #537 entered Resident #12's room without donning any personal protective equipment (PPE). There was a sign posted by the door indicating contact isolation precautions were in place and everyone must wear a gown and gloves when entering the room. On 04/13/26 at 11:34 A.M., an interview with Nurse Aide in Training #537 verified she did not don any PPE prior to entering Resident #12's room. She stated she did not see the sign for contact isolation. Nurse Aide in Training #537 stated Resident #12 needed changed and she changed the resident wearing only gloves. 2. Review of the medical record for Resident #17 revealed an admission date of 11/05/20 with diagnoses including chronic respiratory failure, bipolar disorder, herpes viral infection, and dementia. Review of the physician's orders for Resident #17 identified orders for contact transmission based precautions effective 04/10/26. Review of the care plan dated 04/13/26 revealed Resident #17 was utilizing antiviral medication related to herpes viral infection and was on contact isolation precautions. Interventions included staff to maintain transmission based precautions as ordered. On 04/13/26 at 11:45 A.M., an observation revealed Physical Therapy Assistant (PTA) #656 entered Resident #17's room without donning any personal protective equipment (PPE). There was a sign posted by the door indicating contact isolation precautions were in place and everyone must wear a gown and gloves when entering the room. After entering the room, PTA #656 applied a glove to her right hand and deactivated the call light. An interview at the time of observation with PTA #656 confirmed she did not apply the proper PPE (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to entering the room. PTA #656 stated she did not touch Resident #17 while in the room and she just turned the call light off. PTA #656 confirmed there were no stipulations for contact precautions indicating PPE did not have to be worn in the room if staff were not touching the resident. On 04/13/26 at 11:49 A.M., an interview with Regional Registered Nurse (RN) #649 confirmed she heard PTA #656 say she did not don PPE because she was only turning the call light off and not touching the resident. 3. Resident #40 was admitted to the facility on [DATE] with diagnoses including end stage renal disease dependent on renal dialysis, diabetes, and asthma. Review of the physician's orders for Resident #40 revealed on 04/06/26 the resident was started on Mucinex ER 600 milligrams (mg) every 12 hours for congestion for seven days, Benzonatate 100 mg three times a day for cough for seven days, a Medrol dose pack for help with the resident's asthma, obtain a chest x-ray, and an albuterol inhaler two puffs every six hours for wheezing. Review of the nursing progress notes for Resident #40 revealed on 04/06/26 complained of not feeling well, had a cough, and felt like she was not able to get enough oxygen. The resident tested positive for Covid-19 and was placed on airborne precautions to prevent the further spread of Covid-19. Review of Resident #40's care plans revealed the resident has potential for alteration in respiratory function related to testing positive for Covid-19 on 04/06/26. The care plan was revised to reflect this on 04/15/26. Observation and interview on 04/13/26 from 11:06 A.M. through 11:32 A.M. revealed Resident #40 was on airborne precautions for Covid with personal protective equipment (PPE) located outside the resident's closed door. At 11:06 A.M. Resident #40 activated her call light. The call light remained on at 11:11 A.M. Facility staff were observed going up and down hall past the resident's room while the light was on including Regional Registered Nurses (RRN) #648 and #649. The Assistant Director of Nursing also went up and down the hall without stopping. Resident #40's call light remained on at 11:17 A.M., 11:21 A.M., 11:25 A.M., and 11:30 A.M. At 11:32 A.M. this surveyor asked RRN #649 why the resident's call light had not been responded to since 11:06 A.M. RRN #649 replied she was just going to check on the resident now. RRN #648 then told RRN #649 he would go in and check on the resident, put on a gown, mask, and gloves and entered the room. Eye protection was not in use. Interview with RRN #648 at 11:41 A.M. confirmed eye protection should be worn. This deficiency represents noncompliance investigated under Complaint Number 2800089.