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	07/18/2024

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 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** 28701 Based on resident medical record review, observation and staff interview the facility failed to ensure pressure ulcer wounds were accurately staged. This affected two (Residents #47 and #39) of five residents reviewed for pressure ulcers. The facility identified six residents (Residents #5, #8, #39, #47, #53 and #245) with current pressure ulcer wounds. Findings include: 1. Review of Resident #47's medical record revealed an admitted [DATE] with diagnoses that included Parkinson's disease, Alzheimer's disease with dementia and anemia. Further review of the medical record including care plan, Minimum Data Set (MDS) 3.0 assessment and pressure ulcer risk assessment identified the resident at high risk for the development of pressure ulcer wounds. MDS 3.0 assessment with a reference date of 07/11/24 indicated Resident #47 had a severely impaired cognition level. A nursing note on 07/01/24 indicated Resident #47 was evaluated by the wound nurse practitioner for a new wound which the wound nurse practitioner indicated was a stage three pressure ulcer wound (full thickness skin loss exposing subcutaneous fat). Review of wound grid documentation for Resident #47 revealed on 07/01/24 the resident was found with a stage three pressure ulcer wound to his sacrum. The wound was measured on 07/01/24 as being 2.8 centimeters (cm) long by 1.0 cm wide and 0.1 cm deep with 30% slough (dead cellular debris in a wound bed) and 70% granulation tissue (new tissue). Weekly wound assessments completed on 07/08/24 and 07/15/24 indicated the wound continued as a stage three wound with a depth of 0.1 cm and then less than 0. 1 cm with 100% granulation tissue. Review of the wound nurse practitioner wound evaluation on 07/01/24 indicated the staff reported the sacrum area with erythema and blanching a few days ago but it is opening now. The wound was staged as a stage three pressure ulcer with measurements as 2.8 cm by 1.0 cm and 0.1 cm deep with 30% slough and 70% granulation tissue. Interview with Licensed Practical Nurse (LPN) #375 on 07/16/24 at 1:25 P.M. indicated the area of skin breakdown happened the morning the wound nurse came to the facility for rounds. The resident was assessed by the wound nurse practitioner. The wound was very minimal, open, but only slightly. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the wound on 07/16/24 at 1:35 P.M. with LPN #375 revealed a small and shallow wound to the sacrum of Resident #47. Only partial thickness skin loss was noted at this time with a depth of 0.1 cm. Interview with LPN #375 during wound observation of Resident #47 revealed the wound has improved by getting smaller and wound presents the same as the day of onset presenting as a shallow open wound with only partial thickness skin loss, not full thickness skin loss. No visible subcutaneous fat was observed. On 07/17/24 at 9:10 A.M., LPN #375, Regional Registered Nurse (RN) #500 and the Director of Nursing verified the wound to Resident #47's sacrum was inaccurately staged as a stage three pressure ulcer wound, when it should have been staged as a stage two pressure ulcer wound (partial skin loss with no subcutaneous fat visible). 39333 2. Review of Resident #39's medical record revealed an admitted [DATE] with diagnoses that included but not limited to paraplegia, lymphedema, heart failure, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/28/24, revealed the resident had intact cognition. Further review of the medical record including care plan and pressure ulcer risk assessment identified the resident as high risk for development of pressure ulcer wounds. Review of the wound grid documentation dated 04/08/24 revealed Resident #39 had an in-house acquired stage three pressure ulcer wound located on her left ischium. The wound was measured on 04/08/24 as being 3.0 centimeters (cm) length by 2.5 cm long and 0.1 cm deep with 100% granulation. Weekly wound assessment completed on 05/20/24 indicated the wound continued as a stage three wound with a 1.4 centimeters (cm) length by 1.0 cm long and less than 0.1 cm deep with 100% granulation. Review of the wound nurse practitioner's initial wound evaluation dated 04/08/24 indicated a stage three pressure ulcer located on Resident #39's left ischium. Wound measured 3.0 centimeters (cm) length by 2.5 cm long and 0.1 cm deep with 100% granulation. Interview on 07/17/24 at 10:10 A.M. with Licensed Practical Nurse (LPN) #375 revealed that a pressure ulcer was found on Resident #39's left ischium with an onset date of 04/08/24. LPN #375 indicated the area of skin breakdown happened the morning the wound nurse came to the facility for rounds. The resident was assessed by the wound nurse practitioner. LPN #375 revealed that the wound on Resident #39's left ischium was healed on 06/17/24 and it reopened on 06/24/24. Interview on 07/18/24 at 11:10 A.M., with Regional Registered Nurse (RN) #500 verified the wound to Resident #39's left ischium was inaccurately staged as a stage three pressure ulcer wound, when it should have been staged as a stage two pressure ulcer wound.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review and interview, the facility failed to ensure Resident #30's expired Lantus long-acting insulin was discarded as appropriate. This finding affected one (Resident #30) of two residents who receive insulin on the 100 A medication cart. Findings include: Review of Resident #30's medical record revealed the resident was admitted on [DATE] with diagnoses including major depressive disorder and type two diabetes. Review of Resident #30's physician orders revealed an order dated [DATE] for Lantus insulin 56 units once daily due from 7:00 A.M. to 11:00 A.M. Observation on [DATE] at 7:40 A.M. with Assistant Director of Nursing (ADON) #401 of the 100 A medication cart revealed Resident #30's Lantus long-acting insulin Kwikpen was dated [DATE]. Interview on [DATE] at 7:45 A.M. with ADON #401 confirmed Resident #30's Lantus long-acting insulin Kwikpen was expired and should have been discarded. Review of the Highlights of Prescribing Information (for Lantus) revised ,d+[DATE] revealed the Lantus Kwikpen would need to be discarded after 28 days at room temperature (when in-use or opened).

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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** 34297 Based on observation, record review, interview and policy review, the facility failed to ensure appropriate infection control procedures were maintained while completing Resident #193's wound care. This finding affected one (Resident #193) of five residents reviewed for pressure wounds. Findings include: Review of Resident #193's medical record revealed the resident was admitted on [DATE] with diagnoses including cellulitis of the right lower limb and pressure ulcers to the right and left heels. Review of Resident #193's physician orders revealed an order dated 07/15/24 to apply liquid skin prep/barrier film to the affected area, cover with an abdominal wrap and kerlix daily and as needed; and an order dated 07/15/24 to apply liquid skin prep/barrier film to the affected area, cover with an abdominal pad and wrap with kerlix daily and as needed. Review of Resident #193's left heel pressure wound skin grid dated 07/15/24 authored by Licensed Practical Nurse (LPN) Wound Care Supervisor #375 revealed an unstageable left heel pressure wound which measured 7 cm (centimeters) length by 6.5 cm width by undetermined depth (UTA) with 90% (percent) hard eschar, 5% slough and 5% granulation tissue. Review of Resident #193's right heel pressure wound skin grid dated 07/15/24 authored by LPN Wound Care Supervisor #375 revealed an unstageable right heel pressure wound which measured 2.5 cm length by 1.8 cm width by UTA depth with 100% eschar. Observation on 07/16/24 at 10:32 A.M. with LPN Wound Care Supervisor #375 of Resident #193's bilateral heel pressure ulcers wound care revealed the nurse washed her hands, put on a pair of gloves, placed a pair of scissors on the red isolation bin located in the resident's room, setup a wound care barrier and placed the dressings on the barrier, picked up the scissors from the red isolation bin and cut the old dressings on the resident's bilateral feet which were dated 07/15/24. The nurse placed the scissors back on the red isolation bin, removed the soiled dressings on the resident's bilateral feet, placed a new dressing on her heels between the resident and the bed, removed her gloves and sanitized her hands. The nurse put on a new pair of gloves, cleansed the right heel with normal saline, used skin prep around the peri wound, used an abdominal pad and kerlix around the resident's wound. She picked up the scissors off the red isolation bin and cut the kerlix to fit the resident. She discarded the remaining kerlix. LPN Wound Care Supervisor #375 placed the scissors back on the red isolation bin, removed the soiled dressing on the left heel and placed an abdominal pad on the left heel between the heel and the bed. She removed her gloves and sanitized her hands. LPN Wound Care Supervisor #375 replaced her gloves and cleansed the left heel with normal saline, applied skin prep around the peri wound and wrapped the left heel with the abdominal pad and kerlix. She picked up the scissors off the red isolation bin and cut the kerlix to fit the resident and then discarded the remaining kerlix dressing. She removed her gloves, washed her hands and left the room with the scissors. She placed the scissors on the treatment cart, retrieved a container of bleach wipes and cleansed the scissors with a bleach wipe at the treatment cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/17/24 at 10:40 A.M. with LPN Wound Care Supervisor #375 confirmed she placed the scissors on the contaminated red isolation bin, did not appropriately cleanse the scissors prior to using the scissors to complete Resident #193's bilateral heel pressure ulcer wound care. Review of the undated Pressure Injuries: Assessment, Prevention and Treatment policy revealed it was the facility's policy to identify residents at risk for developing pressure injuries, implement interventions to prevent the development of pressure injuries and provide care for existing pressure injuries.