

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Altercare of Hartville Ctr For		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 Smith Kramer Road Hartville, OH 44632	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>51514</p> <p>Based on resident interview, staff interview, and observation the facility failed to maintain a comfortable environment related to resident room temperatures. This affected one resident (Resident #288) of nine residents reviewed for room temperature.</p> <p>Findings include:</p> <p>On 02/24/25 at 12:38 P.M. Resident #288 was observed seated in a chair and covered with a blanket, watching TV. Interview with the resident revealed the room temperature was cold despite the use of a blanket. Resident #288 also reported their bathroom temperature was even colder.</p> <p>On 02/25/25 at 8:59 A.M. Resident #288 was observed lying in bed, covered with blankets. Interview with the resident revealed they had to ask the facility staff to adjust the temperature in their room higher. After the room temperature was adjusted, it was more comfortable however, the comfortable temperature was not sustained and Resident #288 reported feeling cold again. The resident also reported the bathroom still felt cold.</p> <p>Interview with Regional Plant Maintenance #918 on 02/27/25 at 9:35 A.M. revealed rooms on the 300 and 400 halls were supplied by a central heating source and were controlled by a thermostat. Rooms on the 100 and 200 halls were controlled by a packaged terminal air conditioner (PTAC) which was a self-contained unit that provided both heating and air conditioning. The bathrooms in rooms with a PTAC unit are heated by the PTAC unit and do not have any other heat source. The fan observed in those bathrooms was an exhaust fan only.</p> <p>Observation of room temperature checks with Regional Plant Maintenance #918 on 02/27/25 at 9:35 A.M. revealed Resident #288's room temperature was 68.9 degrees Fahrenheit, and the bathroom temperature was 64.9 degrees Fahrenheit. The temperatures were verified with Regional Plant Maintenance #918.</p> <p>Interview with Resident #288 on 02/27/2025 at 10:07 A.M. confirmed the resident was still cold and the resident didn't want to use the bathroom due to the cold temperature in the bathroom.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on observation, record review, manufacture guideline review and interview, the facility failed to ensure Resident #284's pin care was completed as ordered and Resident #181's left hand rash was provided appropriate skin treatments. This finding affected one (Resident #284) of three residents reviewed for wounds and one (Resident #181) of one for general skin conditions.</p> <p>Findings include:</p> <p>1. Review of Resident #284's Internal Medicine Admission Note History and Physical form dated 02/16/25 revealed the resident had a comminuted, mildly displaced tibia and fibular fractures with associated soft tissue swelling and a prior left total knee arthroplasty.</p> <p>Review of Resident #284's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified fracture of the left tibia subsequent encounter for closed fracture with routine healing, muscle wasting and muscle weakness.</p> <p>Review of Resident #284's physician orders revealed an order dated 02/19/25 (discontinued 02/20/25) for pin care to the left lower leg, swab around the sites with half sterile saline and half hydrogen peroxide once per day, wrap in sites with gauze; an order dated 02/20/25 (discontinued 02/24/25) for pin care to the left lower leg, swab around the sites with half sterile saline and half hydrogen peroxide once per day, wrap pin sites with gauze twice a day; and an order dated 02/24/25 for pin care to the left lower leg, swab around sites with half sterile saline and half hydrogen peroxide once per day, wrap pin sites with gauze.</p> <p>Review of Resident #284's Treatment Administration Records (TARS) from 02/20/25 to 02/27/25 revealed on 02/20/25 at 3:31 P.M. the staff documented the pin care treatment was completed the previous shift and on 02/20/25 at 11:53 P.M. the staff documented the pin care was completed on the previous shift. The TAR on 02/21/25 from the 6:30 A.M. to 10:30 A.M. shift and on 02/22/25 from 6:00 P.M. to 10:00 P.M. revealed the entries were blank.</p> <p>Interview on 02/26/25 at 7:17 A.M. with Resident #284 revealed the facility staff did not complete his left lower leg pin care per the physician's order.</p> <p>Interview on 02/26/25 at 8:10 A.M. with Registered Nurse (RN) Wound Nurse #803 confirmed Resident #284's medical record did not have evidence the resident's left lower leg pin care was completed as ordered.</p> <p>Review of the undated Wound Care policy revealed the was the facility's policy to provide guidelines for the care of wounds to promote healing.</p> <p>2. Review of Resident #181's medical record revealed the resident was admitted on [DATE] with diagnoses including difficulty in walking, muscle weakness and acute kidney failure.</p> <p>Review of Resident #181's physician orders revealed an order dated 02/05/25 for triamcinolone acetonide cream 0.1% apply topically as needed for a rash.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #181's treatment administration records (TARS) from 02/05/25 to 02/27/25 did not reveal evidence the triamcinolone acetonide cream was applied for the resident's rash on the top of the left hand.</p> <p>Review of Resident #181's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.</p> <p>Observation on 02/24/25 at 9:55 A.M. of Resident #181's left hand revealed the top of the hand was edematous with a reddened rash noted. The hand appeared contracted with the fingers curled inward.</p> <p>Interview on 02/24/25 at 9:59 A.M. with Resident #181 indicated the resident's wife was bringing in a splint for his left hand because the splint from the facility had caused a rash on the top of the left hand.</p> <p>Interview on 02/25/25 at 3:53 P.M. with the Certified Occupational Therapy Assistant (COTA) #919 indicated the family was to bring in a splint for the left hand and she was aware of the rash on the top of the left hand for several weeks. COTA #919 confirmed the resident's TARS did not have evidence the triamcinolone acetonide cream for the resident's rash was applied from 02/05/25 to current.</p> <p>Review of Triamcinolone Acetonide Cream 0.1% manufacturer directions dated 02/10/22 revealed the cream was indicated for the relief of the inflammatory and pruritic (intense itching) manifestations of corticosteroid-responsive dermatoses (thousands of different skin conditions).</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</p> <p>Based on record review and interview, the facility failed to arrange transportation for Resident #53's appointment resulting in Resident #53's eye surgery being canceled. This affected one resident (#53) of one reviewed for vision. The facility census was 75.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #53 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, hypertension, hyperlipidemia, generalized anxiety disorder, and depression.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/25/25, revealed Resident #53 was cognitively intact, had impaired vision and wore corrective lenses.</p> <p>Review of the physician's order, dated 02/11/25, revealed Resident #53 had an appointment on 02/24/25 at a surgical center and transportation would need updated.</p> <p>Review of the progress note dated 02/20/25 at 5:10 P.M. revealed Resident #53 had a scheduled surgery on 02/24/25 and was to receive nothing by mouth (NPO) after midnight.</p> <p>Review of the progress note dated 02/24/25 at 7:00 A.M. indicated Resident #53 was NPO after midnight for an eye appointment for cataracts. The note indicated transportation did not arrive to pick up Resident #53.</p> <p>On 02/24/25 at 9:49 A.M., interview with Resident #53 stated the facility did not arrange transportation for her eye surgery and her surgery had to be canceled.</p> <p>On 02/24/25 at 10:21 A.M., interview with Registered Nurse (RN) #886 confirmed transportation never arrived to pick up Resident #53 for her scheduled surgery.</p> <p>On 02/24/25 at 12:13 P.M., interview with Licensed Practical Nurse (LPN) #896 verified Resident #53's eye surgery had to be rescheduled due to transportation issues. LPN #896 said the surgery center did not inform the facility of an arrival time for Resident #53's surgery.</p> <p>On 02/25/25 at 3:37 P.M., interview with Surgery Center Clinical Manager #914 stated Resident #53's eye surgery on 02/24/25 was canceled because Resident #53 did not show up. She further stated she called the facility at the end of the previous week to notify them that Resident #53's arrival time for surgery was 10:00 A.M.</p> <p>On 02/26/25 at 9:22 A.M., interview with RN #801 verified the surgery center had called on 02/20/25 to notify of Resident #53's arrival time of 10:00 A.M. on 02/24/25. RN #801 stated she did not inform transportation because that was the responsibility of LPN #896.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/26/25 at 10:56 A.M., interview with RN #884 confirmed the surgery center called on 02/20/25 and notified that Resident #53 was scheduled to arrive at 10:00 A.M. on 02/24/25. RN #884 stated LPN #896 was notified of the arrival time so transportation could be updated.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51514</p> <p>Based on record review and staff interview, the facility failed to ensure a fourteen day stop date for a as needed (PRN) psychotropic medication. [NAME] affected one resident (Resident #289) out of five residents reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #289 was admitted to the facility on [DATE]. Diagnoses included schizoaffective (mental health) disorder, cardiomyopathy (heart disorder), heart failure, enterocolitis due to Clostridium difficile (a bacterial infection causing frequent diarrhea), weakness, repeated falls, leg pain, and need for assistance with personal care.</p> <p>Review of physician's orders revealed an order for Klonopin (anti-anxiety) 0.5 mg once a day as needed (PRN). The order start date was 02/20/2025 and the end date was entered as Open Ended.</p> <p>Interview on 02/26/25 at 8:51 A.M. with Regional RN #916 verified there was not a stop date for Klonopin 0.5 mg PRN.</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653</p> <p>Based on observation, medical record review, and interview, the facility failed to ensure dentist recommendations for oral surgery services were implemented for one (Resident #21) of two residents reviewed for dental services.</p> <p>Findings include:</p> <p>Review of Resident #21's medical record revealed diagnoses including difficulty swallowing, morbid obesity, type two diabetes mellitus, and vascular dementia. A care plan initiated 06/04/21 revealed the potential for alteration in dental/oral status related to age related changes. Interventions included dental evaluations with treatment as necessary.</p> <p>On 02/27/25 at 9:10 A.M., dental notes dated 08/27/24 were reviewed with Dentist representative #920, via interview, who indicated the resident had an examination and prophylaxis provided. Prior authorization had been obtained. A referral had been sent to an oral surgeon and full dentures had been approved. The note indicated would like full mouth extraction with upper and lower dentures. The dentist indicated at least #17, #19, #31, and #32 root tips needed extracted at a minimum.</p> <p>There was no documentation located in the medical record indicating staff sought an oral surgeon or attempted to make an appointment.</p> <p>On 11/27/24, Resident #21 was admitted to hospice.</p> <p>A significant change in status Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #21 had obvious or likely cavity or broken teeth.</p> <p>On 12/11/24 an order was written to discontinue all upcoming appointments due to hospice.</p> <p>On 02/24/25 at 11:24 A.M., Resident #21 stated his teeth were falling out left and right. Resident #21 stated he had received dental services and was informed he needed to go to an oral surgeon. Resident #21 believed he could not take his wheelchair to the oral surgeon. Resident #21 was observed to have missing and broken teeth.</p> <p>On 02/27/25 at 2:06 P.M., Regional Registered Nurse (RN) #916 verified staff were unable to locate any evidence the referral for an oral surgeon to extract all Resident #21's teeth and root tips and provide full upper and lower dentures was addressed.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>34297</p> <p>Based on record review and interview, the facility failed to ensure the Infection Preventionist (IP) was physically in the building conducting the responsibilities of the IP role including the infection prevention control program (IPCP) as required. This finding had the potential to affect all 75 residents in the building.</p> <p>Findings include:</p> <p>Review of Regional Nurse #916's employee schedule from 02/04/25 to 02/24/25 revealed the IP was in the building to conduct IP duties including:</p> <ul style="list-style-type: none"> a. Week one from 02/02/25 to 02/08/25, the IP was in the building on 02/04/25 (eight hours); b. Week two from 02/09/25 to 02/15/25, the IP was in the building on 02/10/25 and 02/14/25 (16 hours); c. Week three from 02/16/25 to 02/22/25, the IP was in the building on 02/20/25 (eight hours). <p>Interview on 02/24/25 at 12:45 P.M. with Regional Nurse #916 confirmed he was in the role of IP since 02/04/25. He confirmed he was scheduled in the building one to two days per week and completed some of the IP duties remotely while at other facilities.</p> <p>Interview on 02/25/25 at 3:57 P.M. with Staffing Coordinator #854 revealed the facility considered part-time as sixteen to twenty-nine hours per week.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Keep all essential equipment working safely.</p> <p>51521</p> <p>Based on observation and interviews, the facility failed to ensure the laundry room and washers were maintained in clean working order. This had the potential to affect all 75 residents residing in the facility.</p> <p>Findings include:</p> <p>On 02/25/25 at 3:19 P.M., a large buildup of lint was observed behind the washers in the second laundry area including lint built up on the cement floors, up the walls, on all pipes, and in the water drain.</p> <p>On 02/25/25 at 3:20 P.M., the observation was verified with Maintenance Coordinator (MC) #804. MC #804 verified he was unaware staff members were required to clean behind the washers and dryers. The dryer lint logs were reviewed and demonstrated that the lint traps were cleaned daily and the overhead and behind the dryer lint traps were cleaned weekly and signed off by MC #804 and Environmental Service Coordinator (EC) #831. There was no mention of checking behind the washers for lint build-up.</p> <p>On 02/25/25 at 3:33 P.M., the observation was verified with (EC) #831 that lint was built up behind the washers.</p> <p>On 02/25/25 at 3:43 P.M., MC #804 and EC #831 confirmed that the lint built up behind the washers in the second laundry area had not been cleaned and was the responsibility of the maintenance department.</p> <p>On 02/25/25 at 3:52 P.M., Regional Registered Nurse (RN) #915 verified the lint was built up behind the washers in the second laundry area, confirming it could be a fire hazard.</p>