

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Altercare Cambridge Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  66731 Old Twenty-One Road Cambridge, OH 43725	

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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765</b></p> <p>Based on observation , review of the medical record and interview with the staff the facility failed to ensure that private identifiable medical information for Resident #10 was not visible on the computer screen and left unattended by staff. This affected one resident ( Resident #40) of four residents observed for medication administration. The facility census was 49.</p> <p>Findings included:</p> <p>Review of the medical record revealed Resident #40 was admitted to the facility on [DATE]. Diagnoses included muscle weakness, chronic obstructive pulmonary disease, diabetes, hypertension, rheumatoid arthritis, major depressive disorder, anxiety disorder, respiratory failure, polyneuropathy, glaucoma, vitamin D deficiency, congestive heart failure, low back pain, irritable bowel syndrome, ulcerative colitis, diverticulitis, intervertebral disc degeneration, chronic pain syndrome, and adult failure to thrive.</p> <p>Observation on 04/16/24 at 7:22 A.M. revealed the facility medication cart was sitting outside room [ROOM NUMBER] with resident information for Resident #40 up on the screen unattended and where any passerby could view the information.</p> <p>On 04/16/24 at 7:25 A.M. an interview with Registered Nurse #110 came out of the room [ROOM NUMBER] and verified she had left Resident #40's private health information up on her computer screen while she went into the resident's room.</p> <p>Review of the undated facility policy titled, HIPAA, revealed protected health information may not be used or disclosed for reasons other than treatment, payment, or health care operations without resident authorization. Do not leave written documents with resident health information in a location that could be seen by unauthorized individuals and keep unattended medical records behind the nurse's station.</p> <p>This deficiency represents noncompliance identified as an incidental finding during the investigation of Complaint Number OH00152284.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35765</p> <p>Based on observation, review of the medical record and interview with staff the facility failed to ensure medications were not left unattended on top of the medication cart and failed to ensure the medication cart was locked while unattended. This had the potential to affect three residents ( Resident #33, #41, and #43) out of 21 who were cognitively impaired and independently mobile on the Rodeo Unit. The facility census was 49.</p> <p>Findings included:</p> <p>Observation on 04/16/24 at 7:22 A.M. revealed the facility medication cart was sitting outside room [ROOM NUMBER] unlocked and with a plastic medicine cup with 12 tablets in it on the top of the cart. The medication in the medication cup was for Resident #40 and contained; one tablet of aspirin (analgesic) 81 mg, one tablet of Buspar (anti-anxiety) 15 mg, one tablet of Carafate (gastrointestinal agent) 1 gram, one tablet of vitamin D 3 ( vitamin) 5000 units, one tablet of Dicyclomine (anti-cholinergic) 20 mg, one tablet of Duloxetine (anti-depressant) 60 mg, one tablet of Hydroxychloroquine (immune-suppressant) 200 mg, one tablet of Lasix (diuretic) 20 mg, one tablet of Leflunomide (immunosuppressant) 20 mg, one tablet of Lyrica (pain medication) 75 mg, one tablet of Pantoprazole heartburn medication) 40 mg, and one tablet of Sulfasalazine (amino acid) 500 mg.</p> <p>On 04/16/24 at 7:25 A.M. an interview with Registered Nurse #110 came out of the room [ROOM NUMBER] and verified she had left the cart unlocked and left medication unattended on the top of her medication cart. She stated the resident wanted to take the medication after she ate.</p> <p>Review of the facility policy titled, Medication Administration, dated 05/20 revealed during medication administration the medication cart was to be kept closed and locked when out of sight of the medication nurse or aide. No medication was to be kept on top of the cart . In addition, privacy was to be maintained for all resident information when not in use.</p> <p>This deficiency identified noncompliance as an incidental finding during the investigation of Complaint Number OH00152284.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35765</p> <p>Based on observations, interview with staff, and review of facility policy the facility failed to ensure staff performed proper hand hygiene during medication administration. This affected two resident ( Resident #34 and #45) out of four observed for medication administration. The facility census was 49.</p> <p>Findings included:</p> <p>Observation on 04/16/24 at 7:27 A.M. revealed Registered Nurse #110 administered medication to Resident #39 then proceeded to return to the medication cart without washing her hands and prepared medication for Resident #34.</p> <p>At 7:33 A.M. RN #110 administered those medication to Resident #34. She then returned to the medication cart without washing her hands.</p> <p>At 7:45 A.M. RN #110 prepared and administered medications for Resident #45 without washing her hands prior however she did wash her hands after she administered the medication.</p> <p>On 04/16/24 at 7:50 A.M. an interview with RN #110 revealed she had not washed her hands after administering medication to Resident #39, before and after administering medication to Resident #34 and prior to administration of medication to Resident #44.</p> <p>Review of the hand washing policy titled, Hand washing/Hand hygiene, dated 11/20 revealed it was the facility policy to provide guidelines to employees for proper and appropriate hand washing and hygiene techniques that would aide in the prevention of the transmission of infections. Hands were to be washed before preparing or handling medications.</p> <p>Review of the facility policy titled, Medication Administration, dated 05/20 revealed the person administering medication adheres to food hand hygiene which included washing hands thoroughly per policy, before beginning a medication pass, prior to handling any medications, and after coming into direct contact with a resident.</p> <p>This deficiency represents noncompliance as an incidental finding identified during the investigation of Complaint Number OH00152284.</p>