STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366128	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Cambridge Inc.	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received timely pain management. This affected one (Resident #50) of three residents reviewed for pain management. The census was 48. Findings include: Record review revealed Resident #50 admitted to the facility on [DATE] with diagnoses including anemia, hypertension, thyroid atrophy, hypomagnesemia, anxiety, and femur fracture with surgical intervention.Review of Resident #50 admission Minimum Data Set (MDS) section C for cognition revealed a Brief Interview for Mental Status Score of 15, indicating Resident #50 was cognitively intact.Review of MDS section J for health conditions revealed Resident #50 was receiving a scheduled pain medication regimen, and received as needed (PRN) pain medication.Review of Resident #50 care plan completed on 06/11/25 revealed Resident #50 has a left hip surgical wound. Goals include resident will have controlled pain and a level of comfort maintained daily. Interventions include to administer pain medications per physicians orders, remind the resident that reporting pain early may improve effectiveness of pain medication, try non medication relief measures such as repositioning pillows, pad, support, diversion, and observe and report if resident is experiencing breakthrough pain with current medication.Review of Resident #50 orders revealed an order starting 06/19/25 and ending on 06/23/25 for Oxycodone tablet 5 milligrams (mg) orally (PO) every four hours (q.4h) PRN.Review of grievance filed by Resident #50 on 06/23/25 with the Director of Nursing (DON) revealed Resident #50 wanted her pain medications more frequently.Review of event statement form completed on 06/24/25 by physical therapy assistant (PTA) #999 revealed Resident #50 had reported to her on the night of 06/22/25 into 06/23/25 she had waiting six hours for pain medicationReview of Resident #50 Narcotic log sheet for Oxycodone 5mg PO q.4h PRN starting 06/20/25 at 4:00 A.M. revealed from 06/20/25 until 06/22/25 Resident #50 received pain medication approximately every four hours for pain, until 06/22/25 when there was a six and a half hour time without medication from 1:13 P.M. until 7:47 P.M. and an eight and a half hour time from 7:47 P.M. until 5:21 A.M. on 06/23/25.Review of Resident #50 Medication Administration Record (MAR) for June of 2025 revealed Oxycodone 5mg PO q.4h PRN administered on 06/22/25 at 12:32 A.M., 4:28 A.M., 9:09 A.M., 1:13 P.M., and 7:47 P.M Resident #50 pain medication was given q.4h until 1:13 P.M. when there was a six and a half hour time between doses.Review of Resident #50 progress notes revealed a note dated 06/22/25 at 8:00 P.M. authored by assistant director of nursing (ADON) stating certified nurse ' s aides (CNA ' s) alerted this nurse that resident was upset, upon entering room Resident #50 demanded a pain pill stating it was due several hours ago. Let the resident know she was just then due to be able to get her PRN dose.Review of Resident #50 Narcotic log, MAR, and progress notes revealed they were due for their PRN dose on 06/22/25 at 5:13 P.M., not 8:00 P.M Review of Resident #50 Narcotic log sheet for Oxycodone 5mg PO q.4h PRN starting 06/20/25 at 4:00 A.M. revealed from 06/20/25 until 06/22/25 Resident #50 received pain medication approximately every four hours for pain, until 06/22/25 when there was a six and a half hour time without medication from 1:13 P.M. until 7:47 P.M Record review revealed no documentation of non-pharmacological pain interventions attempted or implemented to address Resident #50 pain between the hours of 1:13 P.M. 7:47 P.M. on 06/22/25.Review of Resident #50 June 2025 MAR revealed Oxycodone 5mg PO q.4h PRN was given on 06/22/25 at 7:47 P.M. and was not administer again until eight and a half hours later on 06/23/25 at 9 and a half hours later at 5:21 A.M.Review of Resident #50 Narcotic log sheet for Oxycodone 5mg PO q.4h PRN starting 06/20/25 at 4:00 A.M. revealed from 06/20/25 until 06/22/25 Resident #50 received pain medication approximately every four hours for pain, until 06/22/25 when there was an eight and a half hour time without pain medication from 7:47 P.M. until 5:21 A. M. on 06/23/25. After this time Resident #50 began receiving her pain medication every four hours as previous until discontinuation of the order. Record review revealed no documentation of non pharmacological pain interventions attempted or implemented to address Resident #50 pain between the hours of 7:13 P.M. on 06/22/25 and 5:21 A.M. on 06/23/25. Interview on 08/25/25 at 9:25 A.M. with certified nursing assistant (CNA) #888 revealed staff was telling Resident #50 her pain medication was due every eight hours however Resident #50 pain medication was due every four hours at that time. CNA #888 stated on 06/22/25 on night shift into 06/23/25 Resident #50 was upset because she had asked for pain medication several hours prior and still had not received any.Interview on 08/26/25 at 8:41 A.M. with ADON revealed Resident #50 wanted pain medication on 06/22/25, stated Resident #50 is very consistent with timing of her pain medication and knows when they are due.Interview on 08/26/25 at 12:36 P.M. with Resident #50 revealed on 06/22/25 on

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Based on review of the job descriptions, review of the employee handbook, review of a self-reported incident investigation, review of timed stamped and dated photographs, review of Centers for Disease Control (CDC) and the National Institute for Occupational Safety and Health (NIOSH) report, review of the facility assessment, review of time sheets, interviews, and policy review the facility failed to have systems in place to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to prevent staff sleeping while on duty and monitor to ensure licensed staff do not pre-pour medications for residents prior to administration. This had the potential to affect all 48 residents residing in the facility. Findings include: 1. Review of Licensed Practical Nurse (LPN) #133's timecard dated 11/06/25 and 11/07/24 revealed LPN #133 clocked in at 11:54 P.M. on 11/06/25 and clocked out at 6:12 P.M. on 11/07/24. The LPN worked 17.75 hours.Review of photographs dated 11/07/24 at 4:33 A.M., revealed LPN #133 standing in front of medication cart with the card drawer open. There were approximately nine medication cups with several loose pills in the cups and five clear cups set up in a line with no medication in them yet were on top of the medication cart. Interview on 08/25/26 at 9:25 A.M., with Certified Nursing Assistant (CNA) #888 confirmed LPN #133 pre-pouring medication and groups medication administration times (morning and afternoon medication times) together so she only has one medication pass. Residents will question their medication and LPN #133 would tell residents the medication was correct and just take them. Administration staff were aware, and several staff had reported LPN #133, but nothing was addressed and the nurse continued to pre-pour medications. Several staff ended up resigning due to the nurse's negligence. Interview on 08/25/25 at 1:06 P.M., with LPN #133 and the Director of Nursing (DON) revealed LPN #133 confirmed she was the nurse in the photo dated 11/07/24 at 4:33 A.M. pre-pouring medications for administration. The LPN reported she had occasionally pre-poured medication to get a jump start on the day. The DON reported she was not aware the LPN was pre-pouring medications and staff should not be pre-pouring medications (for a later administration). Interview and review of LPN #133's timecard on 08/26/25 at 11:16 A.M., with Registered Nurse (RN) #100 verified the nurse worked 17.75 hours on 11/07/24.Review of LPN #133's job description dated 09/19/23 revealed the LPN would administer scheduled medications to residents in a timely manner, ensuring proper and correct dosages were given. Properly records administration on the Medication Administration Records (MAR). Follows the facility's policy and procedures for administrating medications. Review of the facility's policy titled Medication Administration-General Guideline dated 05/2020 revealed when medications are administered by mobile cart the cart is taken to the resident location and administered at the time they are prepared. Medication is not pre-poured either in advance of the medication pass or for more than one resident at a time. 2. Review of a photograph of a Facebook post dated 06/23/25 revealed Resident #50 had posted two pictures of LPN #133 asleep on the couch in the common area. The post indicated this was the dayshift nurse (nurses name posted) at (facility's name posted) sleeping on night shift at 3:30 A.M. The nurse picks up all the hours, now we know how she does it. Feel sorry for the residents that need help, like me. I have been waiting for my pain medication for almost six hours. Review of pictures/videos dated 06/23/25 at 1.38 A.M, 1:45 A.M., 2:29 A.M., and 4:03 A.M., revealed LPN #133 on the couch in the common area, asleep. Review of Self-Reported Incident (SRI) Tracking Number 261941, dated 06/23/25, revealed Resident #50 alleges she went too long without pain medication. Review of the investigation revealed a statement authored by Registered Nurse (RN) #152 that indicated on 06/22/25 into 06/23/25 she had walked over to the other unit approximately midnight to get medication and asked the Assistant Director of Nursing (ADON) for the medication room keys. The ADON stated she had given the keys to LPN #133. RN #152 went to ask LPN #133 for the medication keys, and she was observed on the couch in the day area covered up with a blanket, sleeping. RN #152 woke her up and she stated she didn't have the keys and went back to sleep. RN #152 told the ADON that LPN #133 stated she didn't have the keys. The ADON stated LPN #133 had the keys and they just had counted the narcotic drawer. RN #152 stated she returned to her unit and thought she would get the medication she needed later. The lab technician came over at approximately 3:30 A.M. and asked if there were labs on the other unit due to there being no log and the nurse was asleep, and she could not wake her. Both CNAs were present during the conversation. RN #152 had gone back to LPN #133's unit at 5:30 A.M. to get medication out of the medication room and LPN #133 had asked if lab had been there. LPN #133 reported she was unable to print the labs off the computer. RN #152 told LPN #133 she could have called her over and she could have