

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 09/05/2024
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019</p> <p>Based on medical record review and staff interview, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) document accurately reflected medications and a psychiatric hospitalization . This affected one (Resident #37) of four residents reviewed for PASRR documents. The census was 46.</p> <p>Findings Include:</p> <p>Medical record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, Alzheimer's disease, major depressive disorder, delusional disorder, dementia with psychotic disturbance, and panic disorder.</p> <p>Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 07/19/24, revealed the resident was severely cognitively impaired and received an anti-anxiety medication.</p> <p>Review of Resident #37's PASRR document, dated 08/26/24, revealed under Section E, no anti-anxiety medication. Review of the resident's physician orders, dated 03/29/24, revealed the order for Xanax 0.5 milligrams (mg) to be administered three times per day. Review of the medication administration record (MAR), dated August 2024, revealed the resident received this medication as ordered. Further review of the PASRR document under Section E, incorrectly indicated the resident had not been hospitalized for inpatient psychiatry. Review of Resident #37's medical record revealed the resident was hospitalized on [DATE] due to increased confusion, paranoia, believing he was breaking up a prostitution ring, making sexual comments to staff, delusions, grandiosity, and having trouble sleeping.</p> <p>During interview on 09/03/24 at 4:41 P.M., Social Services Designee (SSD) #194 confirmed Resident #37's PASRR document was not accurate and did not indicate the use of an anti-anxiety medication nor the inpatient psychiatric hospitalization on [DATE].</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701</p> <p>Based on observation, resident interview, record review, policy review and staff interview, the facility failed to ensure oxygen tubing was changed weekly and documented as administered in the medical record. This affected one (Resident #8) of two residents reviewed for supplemental oxygen use. The facility census was 46.</p> <p>Findings include:</p> <p>Observations of Resident #8 on 09/03/24 at 9:26 A.M. revealed the resident lying in bed. Supplemental oxygen was supplied by an oxygen concentrator (machine that separates nitrogen from atmospheric air delivering 95% pure oxygen) via a nasal cannula. No evidence of any date to the tubing and nasal cannula was observed. Additional observations of Resident #8 on 09/03/24 at 3:58 P.M., 09/04/24 at 7:38 A.M. and 09/04/24 at 12:05 P.M. revealed supplemental oxygen in use by Resident #8 with no date on the tubing. Observation on 09/05/24 at 9:50 A.M. revealed Resident #8 sitting in her recliner and supplemental oxygen lying on her bed with the tubing undated.</p> <p>Interview with Resident #8 on 09/05/24 at 9:50 A.M. revealed that she uses the supplemental oxygen when in bed every day. She could not recall when the oxygen tubing was replaced.</p> <p>Review of Resident #8's medical record revealed an admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease, Parkinson's disease and cerebrovascular accident. Further review of the medical record including Minimum Data Set (MDS) 3.0 significant change assessment with a reference date of 08/09/24 indicated Resident #8 had an independent and intact cognition level and used supplemental oxygen therapy.</p> <p>Physician's orders for Resident #8 indicated on 08/03/24 an order for two liters of supplemental oxygen as needed for a blood oxygen saturation level lower than 89%. No order was found related to replacing the oxygen tubing routinely.</p> <p>Progress notes revealed as needed supplemental oxygen was utilized by Resident #8 on 08/03/24, 08/05/24, 08/06/24, 08/07/24, 08/11/24, 08/12/24, 08/18/24, 08/20/24, 08/24/24, 08/25/24, 08/26/24, 08/27/24, 08/30/24 and 09/02/24. An additional progress note dated 08/11/24 indicated Resident #8 uses the supplemental oxygen every night while sleeping. No evidence of changing the oxygen tubing was found in the progress notes.</p> <p>Review of the Medication Administration Record (MAR) revealed documentation of supplemental oxygen administered as ordered on 08/03/24, 08/05/24, 08/17/24 and 09/01/24. No evidence of changing oxygen tubing was found on the MAR.</p> <p>On 09/03/24 at 3:20 P.M. interview with Licensed Practical Nurse (LPN) #133 indicated residents on supplemental oxygen therapy have tubing changed weekly on Fridays by a contracted oxygen supply company.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/05/24 at 9:55 A.M. interview with the Director of Nursing verified Resident #8's oxygen tubing and nasal cannula were not dated and unknown when last replaced. The DON also verified supplemental oxygen use was not consistently documented as administered on the MAR.</p> <p>Review of the facility policy titled Respiratory Treatment Oxygen dated 05/19/21 indicated to change oxygen tubing, nasal cannula every seven days.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923</p> <p>Based on record review, review of a meal ticket, observation, resident interview, staff interview, and policy review, the facility failed to ensure there was consistent communication between the facility and the dialysis center regarding a resident's hemodialysis treatments. They also failed to ensure the medical record accurately reflected the resident's current order for a fluid restriction and staff were knowledgeable about the resident's need for a fluid restriction as ordered for end stage renal disease. This affected one (Resident #19) of one resident reviewed for dialysis.</p> <p>Findings include:</p> <p>1 a.) Review of Resident #19's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included end stage renal disease, dependence on renal dialysis, pulmonary hypertension, and congestive heart failure.</p> <p>Review of Resident #19's physician's orders revealed the resident had an order for dialysis treatments every Monday, Wednesday, and Friday. The order originated on 08/19/23.</p> <p>Review of Resident #19's active care plans revealed she had a care plan in place for an alteration in renal function, as the resident was receiving renal dialysis. The care plan was initiated on 06/28/23 and indicated the facility was to encourage the dialysis center to forward dialysis treatment notes to the facility.</p> <p>Review of Resident #19's medical record revealed it was absent for most of the dialysis visit notes for the resident's dialysis treatments she received in the past 30 days. Out of the 14 times the resident was sent out of the facility for a dialysis treatment, 13 of those visits did not have a dialysis visit note to indicate what the resident's pre-weight and dry weight (weight after dialysis) were, what her vital signs were, what medications she had been given, and how the resident tolerated the dialysis treatment during each visit.</p> <p>On 09/03/24 at 2:22 P.M. an interview with Resident #19 revealed she did not believe the facility was sending her to the dialysis center with any paperwork. She also denied the dialysis center had sent her back to the facility with any dialysis visit notes. She did not feel the facility and the dialysis center were communicating as well as they should.</p> <p>On 09/04/24 at 3:02 P.M., an interview with LPN #133 revealed the facility's nurses completed dialysis observation assessments on Resident #19 before and after she had her dialysis treatments. She denied those dialysis observation forms that were completed were sent with the resident to dialysis. She further denied the resident was sent back to the facility with any dialysis visit notes. Any communication made between the dialysis center and the facility would be done by the dialysis center calling them. She indicated they may get a call from the dialysis center on occasion, if there was a new order or a change in the resident's condition. She denied the facility would know what the resident's weights and vital signs were pre and post-dialysis. They would also not know what medications the resident received while at dialysis, or how she tolerated the treatment.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/05/24 at 10:10 A.M., findings were verified by the Director of Nursing (DON) and RN #220 that Resident #19's electronic medical record (EMR) did not show evidence of consistent and adequate communication occurring between the facility and the resident's dialysis center. They acknowledged the dialysis center was not sending a dialysis visit note for the resident that let them know what the resident's pre-weight and dry weight was when the resident received hemodialysis. There was also no communication of any medications that may have been administered to the resident or how she tolerated the dialysis treatment while there. They acknowledged their policy and the resident's plan of care indicated the facility was to receive a dialysis visit note from the dialysis center when the resident received her treatments three days a week.</p> <p>The facility's dialysis policy updated 2024 was reviewed and revealed it was the policy of the facility that all residents utilizing renal dialysis receive comprehensive interdisciplinary monitoring to ensure resident safety and support of dialysis services. The dialysis center would send reports from the resident's dialysis treatments to the facility after each visit.</p> <p>1 b.) Review of Resident #19's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included end stage renal disease (ESRD), dependence on renal dialysis, pulmonary hypertension, and congestive heart failure.</p> <p>Review of Resident #19's physician's orders revealed the resident had an order in place for a 1,500 milliliter (ml)/ day fluid restriction with directions for dietary to provide 1,000 ml and nursing to provide 500 ml to equal the 1,500 ml/ day. The 500 ml allotted to nursing was further broke down to 250 ml on the day shift and 250 ml on the night shift. The order had been in place since 04/26/24.</p> <p>Review of Resident #19's active care plans revealed the resident had a care plan in place for an alteration in renal function, as the resident was receiving renal dialysis for ESRD. The care plan was initiated on 06/28/23 and indicated the resident was on a 1,200 ml/ day fluid restriction with nursing and dietary dividing fluids with meals and daily care including medication passes. The care plan intervention was not consistent with what was specified in the physician's orders. That intervention for the 1,200 ml/ day fluid restriction had been in place since 06/28/23.</p> <p>Further review of Resident #19's care plans revealed she had another care plan in place for being at risk for altered nutrition related to ESRD and being on hemodialysis. That care plan indicated the resident was on a 1,500 ml/ day fluid restriction, which was not consistent with what was indicated on the alteration in renal function care plan. The care plan for the resident's risk for altered nutrition was last revised on 08/15/24.</p> <p>Review of Resident #19's meal ticket for 09/05/24 revealed the resident was identified as being on a 1,200 ml fluid restriction. It did not break it down on the meal ticket to specify how much fluid the resident should be given for each meal.</p> <p>On 09/03/24 at 2:22 P.M. an observation of Resident #19 noted her to be in her room. She was noted to have a can of pop in her room and a full Styrofoam cup of water. The resident was not sure if she was on a fluid restriction or not for her dialysis.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/05/24 at 8:06 A.M., an interview with State tested Nursing Assistant (STNA) #144 revealed she was not aware of Resident #19 being on a fluid restriction. She indicated they gave the resident the same amount of water in her Styrofoam cup as the other residents received. She indicated the resident usually did not drink all of what was given to her in her Styrofoam cup and thought she only drank about 240 ml from it. She usually did drink what they sent on her meal trays. She then indicated, since the resident was on dialysis, she likely was on a fluid restriction, as most of them were. She did not know what amount of fluids the resident could have, if she was on a fluid restriction. She felt the resident probably drank what she was able to, but did not know for sure, as they did not know what she drank when out of the facility with her family.</p> <p>On 09/05/24 at 10:10 A.M., findings were verified by the DON and RN #220 that Resident #19's care plans, physician's orders, and meal ticket were unclear on the amount of the fluid restriction the resident was to be on. They acknowledged the discrepancy in the amount of fluids that the resident could have as documented on her two care plans, physician's orders, and meal ticket. They confirmed the resident's current order was for a 1,500 ml/ day fluid restriction and the care plans and meal ticket should all reflect such. They further acknowledged the STNA interviewed, who was caring for Resident #19, was unaware she was on a fluid restriction and was providing the resident water in a Styrofoam cup just like they did with all the other residents.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701</p> <p>Based on observation, medical record review and staff interview, the facility failed to follow appropriate transmission based precautions for a resident on contact precautions. The affected one (Resident #253) of two residents identified on transmission based precautions. The facility census was 46.</p> <p>Findings include:</p> <p>Review of Resident #253's medical record revealed an admitted [DATE] with diagnoses that included enterocolitis due to clostridium difficile, sepsis, pneumonia and chronic obstructive pulmonary disease. Physician's orders upon admission indicated Resident #253 required contact transmission based precautions and resident to remain in his room related to signs of symptoms of a highly transmissible disease or epidemiologically significant pathogen.</p> <p>Observation on 09/04/24 at 2:20 P.M. revealed Activity Coordinator (AC) #192 in Resident #253's room. A sign was posted on Resident #253's door frame indicating he was on contact precautions and a cart containing personal protective supplies was noted below the sign and outside the resident's room door. AC #192 was sitting on the edge of Resident #253's bed and was wearing a protective gown and gloves. The gown was tied twice in the back but was open with approximately a three to four inch opening with AC #192's pants contacting the linens of Resident #253's bed. Resident #253 was observed sitting in a recliner next to the bed. Resident #253 was observed in the bed earlier in the day.</p> <p>On 09/04/24 at 2:22 P.M. interview with AC #192 indicated she was completing an activity assessment for Resident #253. She verified the resident had contact precautions in place for C-Diff and should not have been sitting on the residents bed with her personal clothing exposed and contacting the bed linens.</p> <p>On 09/04/24 at 2:40 P.M. AC #192 indicated she changed into new nursing scrubs after informing the Director of Nursing and Administrator of the incident.</p>		