

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2024
NAME OF PROVIDER OR SUPPLIER  Altercare of Mayfield Village, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  290 North Commons Blvd Mayfield Village, OH 44143	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39973</p> <p>Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #30 had a comprehensive care plan regarding interventions to maintain her peripherally inserted central catheter (PICC) (a catheter inserted through the arm vein and passed through to larger veins near the heart) line and monitor her intravenous (IV) antibiotics. This affected one resident (#30) out of three residents reviewed for care plans. The facility census was 41.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including endocarditis (serious infection of the heart's inner lining), cognitive communication deficit, hypotension, and heart failure.</p> <p>Review of the undated comprehensive care plan revealed Resident #30's care plan only included areas related to activities and nutrition. There was nothing in her care plan related to interventions to maintain the PICC line or the IV antibiotic use due to endocarditis.</p> <p>Review of the November 2024 physician orders revealed Resident #30 had the following orders: an order dated 11/01/24 for ceftriaxone (antibiotic) two grams per IV every 24 hours, an order dated 11/01/24 vancomycin (antibiotic) 750 milligram (mg) IV every 12 hours, an order dated 11/08/24 to flush the PICC line before and after each dose of IV antibiotic with a normal saline flush (sodium chloride) 0.9 percent 10 cubic centimeter (cc) twice a day, an order dated 11/08/24 to check the PICC line site every shift, an order dated 11/08/24 to change intermittent IV tubing every 24 hours, and an order dated 11/08/24 to change right arm PICC line dressing every seven days.</p> <p>Review of the November 2024 Medication Administration Record (MAR) revealed Resident #30 received IV antibiotics beginning 11/02/24 as ordered, but she did not have documented evidence that the PICC line was flushed before and after antibiotic therapy. There also was no documented evidence that the PICC line site was assessed and the IV tubing changed prior to 11/08/24.</p> <p>Review of the November 2024 Treatment Administration Record (TAR) revealed an order dated 11/08/24 to change Resident #30's right arm PICC line dressing every seven days. It was documented as completed on 11/08/24 by Agency Registered Nurse (RN) #610 and on 11/15/24 by Licensed Practical Nurse (LPN) #604.</p> <p>(continued on next page)</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #30 had intact cognition and received IV antibiotics.</p> <p>Interview on 12/03/24 at 8:25 A.M. with Resident #30's daughter revealed Resident #30 was displaying increased confusion on 11/17/24, and the physician ordered her to go to the hospital. While in the emergency room , it was discovered that her PICC line dressing was dated as being last changed on 10/29/24 (18 days). The hospital staff told her PICC line dressings were to be changed at least every seven days to prevent infection, and she was concerned especially since her mother already was being treated for a heart infection (endocarditis).</p> <p>Interview and observation on 12/03/24 at 8:31 A.M. revealed Resident #30 had a PICC line to her right upper arm with a dressing over the site dated 12/01/24. She stated that she was unsure how often she had the dressing changed and/or who changed her dressing.</p> <p>Interview on 12/03/24 at 10:46 A.M. and 1:07 P.M. with the Director of Nursing (DON) and Regional Nurse #603 revealed Resident #30 was admitted to the facility with a PICC line and IV antibiotics on 11/01/24. Regional Nurse #603 revealed she was in the facility on 11/08/24 and had completed a chart audit and noticed that Resident #30 did not have flush orders to flush the PICC line before and after the antibiotics, to change her IV tubing every 24 hours or to change her PICC line dressing. She brought this to the attention of the DON and the orders were obtained on 11/08/24. They verified from 11/01/24 till 11/08/24 Resident #30 did not have flush orders to flush the PICC line before and after antibiotics and did not have an order to change the IV tubing every 24 hours. The DON verified that the Administrator received a call from Resident #30's daughter concerned that when Resident #30 went to the emergency roaignom on [DATE] they had discovered that her PICC line dressing was dated 10/29/24 (18 days). The DON revealed she educated the nurses regarding changing PICC line dressings. They also verified there was nothing in Resident #30's care plan related to interventions to maintain the PICC line or to monitor the IV antibiotics.</p> <p>Interview on 12/03/24 at 12:58 P.M. with MDS/RN #609 verified that the comprehensive care plan did not include anything related to the care and maintenance of Resident #30's PICC line and/or the IV antibiotics for endocarditis.</p> <p>Interview on 12/03/24 at 1:38 P.M. with Agency RN #610 revealed she only had worked at the facility twice and that she had never changed an IV dressing while at the facility, including Resident #30's PICC line dressing. She stated that she must have accidentally signed off that she completed the dressing change on 11/08/24 for Resident #30. She stated that she was not familiar with the electronic documentation system that the facility used as it was different than what she was used to and felt that was the reason that she signed off the dressing being changed in error.</p> <p>Review of the facility policy labeled; Care Planning, dated 2024, revealed the facility interdisciplinary team was responsible to develop an individualized comprehensive care plan for each resident. The policy revealed a comprehensive care plan was to be developed within 21 days of admission to the facility and would be updated by a member as changes in resident's condition occurred. There was nothing in the policy in regards what was to be included in the care plan.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00160056.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39973</p> <p>Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #30's peripherally inserted central catheter (PICC) (a catheter inserted through the vein in the arm and passed through to larger veins near the heart) line dressing changes were changed as ordered, and failed to ensure physician's orders were obtained to maintain the PICC line, including flushing before and after intravenous (IV) antibiotic therapy and changing of IV tubing timely. This affected one resident (#30) out of one resident with an IV. The facility census was 41.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including endocarditis (serious infection of the heart's inner lining), cognitive communication deficit, hypotension, and heart failure.</p> <p>Review of the undated comprehensive care plan revealed Resident #30's care plan only included areas related to activities and nutrition. There was nothing in her care plan related to interventions to maintain the PICC line or the IV antibiotic use due to endocarditis.</p> <p>Review of the November 2024 physician orders revealed Resident #30 had the following orders: an order dated 11/01/24 for ceftriaxone (antibiotic) two grams per IV every 24 hours, an order dated 11/01/24 vancomycin (antibiotic) 750 milligram (mg) IV every 12 hours, an order dated 11/08/24 to flush the PICC line before and after each dose of IV antibiotic with normal saline flush (sodium chloride) 0.9 percent 10 cubic centimeter (cc) twice a day, an order dated 11/08/24 to check the PICC line site every shift, an order dated 11/08/24 to change intermittent IV tubing every 24 hours and an order dated 11/08/24 to change the right arm PICC line dressing every seven days.</p> <p>Review of the November 2024 Medication Administration Record (MAR) revealed Resident #30 received IV antibiotics beginning 11/02/24 as ordered, but she did not have orders and/ or documented evidence that the PICC line was flushed before and after IV antibiotic therapy. There was also no document evidence that the PICC line site was assessed and the IV tubing changed prior to 11/08/24.</p> <p>Review of the November 2024 Treatment Administration Record (TAR) revealed an order dated 11/08/24 to change Resident #30's right arm PICC line dressing every seven days. It was documented as completed on 11/08/24 by Agency Registered Nurse (RN) #610 and on 11/15/24 by Licensed Practical Nurse (LPN) #604.</p> <p>Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #30 had intact cognition and received IV antibiotics.</p> <p>Review of the nursing note dated 11/16/24 at 11:50 P.M. and authored by LPN #800 revealed Resident #30 had a change in mental status as she had increased confusion. Physician #950 was notified and ordered Resident #30 to be evaluated at the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Emergency Department Provider Note dated 11/17/24 and authored by Physician #900 revealed Resident #30 was evaluated as over the past day she felt more confused than usual. She had been receiving IV ceftriaxone and vancomycin due to endocarditis. She was discharged back to the facility without any abnormal findings on evaluation and/or lab testing. Physician #900 ordered to continue the current antibiotics.</p> <p>Observation of photo taken by Resident #30's daughter when Resident #30 was at the hospital revealed a PICC line to Resident #30's right upper arm with a dressing covering the PICC line site dated 10/29/24. (Resident #30's daughter stated she took the photograph 11/17/24 at 1:57 A.M. of Resident #30 right arm).</p> <p>Review of the grievance form dated 11/18/24 revealed Resident #30's daughter called the Administrator with a concern regarding when Resident #30 was at the hospital, it was discovered that Resident #30's PICC line dressing was outdated. The form revealed on 11/18/24 the Director of Nursing (DON) interviewed all involved staff and educated the staff on the importance of checking the dressing daily and changing the dressing according to the physician's order and as needed to ensure standard of care was provided.</p> <p>Interview on 12/03/24 at 8:25 A.M. with Resident #30's daughter revealed Resident #30 was displaying increased confusion on 11/17/24, and the physician ordered her to go to the hospital. While in the emergency room , it was discovered that the PICC line dressing was dated as last changed on 10/29/24 (18 days). The hospital told her PICC line dressings were to be changed at least every seven days to prevent infection, and she was concerned especially since her mother was being treated for a heart infection (endocarditis).</p> <p>Interview and observation on 12/03/24 at 8:31 A.M. revealed Resident #30 had a PICC line to her right upper arm with a dressing over the site dated 12/01/24. She revealed that she was unsure how often the dressing was changed and/or who changed the dressing.</p> <p>Interview on 12/03/24 at 10:46 A.M. and 1:07 P.M. with the Director of Nursing (DON) and Regional Nurse #603 revealed Resident #30 was admitted to the facility with a PICC line and IV antibiotics on 11/01/24. Regional Nurse #603 revealed she was in the facility on 11/08/24 and had completed a chart audit and noticed that Resident #30 did not have flush orders to flush the PICC line before and after the antibiotics, to change her IV tubing every 24 hours or to change her PICC line dressing. She brought this to the attention of the DON and the orders were obtained on 11/08/24. They verified from 11/01/24 till 11/08/24 Resident #30 did not have flush orders to flush the PICC line before and after antibiotics and did not have an order to change the IV tubing every 24 hours. The DON verified that the Administrator received a call from Resident #30's daughter concerned that when Resident #30 went to the emergency roiaqnom on [DATE] they had discovered that her PICC line dressing was dated 10/29/24 (18 days). The DON revealed she educated the nurses regarding changing PICC line dressings.</p> <p>Interview on 12/03/24 at 12:58 P.M. with MDS/ RN #609 verified that the comprehensive care plan did not include anything related to the care and maintenance of Resident #30's PICC line and/or the IV antibiotics for endocarditis.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/03/24 at 1:10 P.M. with the Administrator revealed she had received a call from Resident #30's daughter on 11/18/24, and she voiced a concern that when Resident #30 was at the hospital on 11/17/24, the hospital noticed that Resident #30's PICC line dressing was last changed on 10/29/24, and that the dressing was to be changed every seven days. She apologized to Resident #30's daughter and brought the concern to the attention of the DON who provided education to the nursing department.</p> <p>Interview on 12/03/24 at 1:38 P.M. with Agency RN #610 revealed she only had worked at the facility twice and that she had never changed an IV dressing while at the facility, including Resident #30's PICC line dressing. She stated that she must have accidentally signed off that she completed the dressing change on 11/08/24 for Resident #30. She stated that she was not familiar with the electronic documentation system that the facility used as it was different than what she was used to and felt that was the reason that she signed off the dressing being changed in error.</p> <p>Review of the undated facility policy labeled, Dressing Change and Care of PICC revealed the purpose was to reduce the risk of system infections and minimize the contamination of the catheter system. The policy revealed dressings were to be changed every seven days using a sterile technique and immediately if the integrity of the dressing was in anyway compromised. The policy revealed the dressing was to be labeled with date, time and nurse's initials and the procedure was to be documented.</p> <p>Review of the undated facility policy labeled, Flushing PICC Line revealed the purpose of the policy was to prevent blood clot formation in the catheter or at the tip and decrease the possibility of any drug interaction in the catheter. The PICC line was to be flushed every 24 hours with 10 cc of .9 percent sodium chloride when not in use and before and after each intermittent medication. The policy revealed the procedure included verifying the physician order and documenting the procedure.</p> <p>Review of the undated facility policy labeled; Tubing Set-Up revealed the purpose of the policy was to maintain sterility of the intravenous set-up. The tubing was to be set up by using an aseptic technique. The policy revealed the nurse was to verify the order and label the tubing with date, time and nurse's initials. The policy revealed the nurse was to document the procedure.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00160056.</p>		