STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366267	A. Building B. Wing	12/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Mayfield Village, Inc	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, resident interview, and facility procedure review, the facility failed to ensure medications were ordered and available in a timely manner for newly admitted residents. This affected one (Resident #41) of three residents reviewed for timely medication administration. The census was 42. Findings Include: Review of the medical record for Resident #41 revealed she was admitted to the facility on [DATE]. Her diagnoses were chronic kidney disease (stage IV), spinal stenosis, weakness, need for assistance with personal care, difficulty walking, obstructive and reflux uropathy, schizophrenia, spondylosis, migraine, schizoaffective disorder, and major depressive disorder. Review of Resident #41's progress note dated 12/11/24 revealed she was admitted to the facility on [DATE] at approximately 8:14 P.M. Review of Resident #41's progress note dated 12/12/24 revealed information that some medications needed to be clarified with the physician and faxed to the pharmacy. The note also stated that the medications were drop shipped, which was expedited shipping from the pharmacy, so she could get all of her medications in the facility. Within the same note, the nurse documented that Resident #41's family was upset that the resident's medications had not been sent to the facility in a timely manner. Review of Resident #41 hospital discharge documents dated 12/11/24 revealed a comprehensive list of medications she was taking in the hospital, and then a comprehensive list of medications she was to take when she was admitted to the nursing facility. The medications listed to be ordered at the nursing facility included Tizanidine four milligrams (mg) three times daily for muscle spasms and Oxycodone five mg every six hours as needed with instructions to give one tablet for a pain level of one to four and two tablets for a pain level of five to ten (on a pain scale of zero to ten, zero indicating no pain and ten indicating the worst pain). (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #41's Medication Administration Records (MAR) for December 2024 revealed the following medications were unavailable and not included in the initial medication shipment on the morning of 12/12/24: Tizanidine four mg three times daily for muscle spasms (due at three separate ranges of time from 7:00 A.M. to 11:00 A.M., 1:00 P.M. to 2:30 P.M., and 7:00 P.M. to 11:00 P.M.) and Oxycodone five mg every six hours as needed with instructions to give one tablet for a pain level of one to four and two tablets for a pain level of five to ten. These medications were not shipped to the facility or administered to the resident until the afternoon of 12/12/24. Interview with the Administrator on 12/21/24 at 10:35 A.M. revealed she was aware of Resident #41's issue with not having medication in the facility when she was first admitted and the family not being happy with that. Based on the information she received from the floor nursing staff, Resident #41's medications (all except for two) had arrived and been administered as ordered. They were waiting for the Tizanidine and Oxycodone from the pharmacy, which with being drop shipped, those medications arrived later in the afternoon of 12/12/24 and were then administered. Interview with Licensed Practical Nurse (LPN) #101 on 12/21/24 at 12:35 P.M. confirmed she was the morning nurse on 12/12/24. She received shift change report from LPN #102, who was the admitting nurse the night before. She was told the medications could not be drop shipped the night before because there were too many, so they were going to be delivered that morning when the pharmacy could bring them. She confirmed she received all the medications except for Tizanidine and Oxycodone, which the pharmacy needed hard copy prescriptions for. She looked through the hospital discharge paperwork and found a sealed envelope with the hospital stamp on it. She stated she opened the envelope and found the hard copy prescriptions for those two medications. She sent them to the pharmacy and had those medications drop shipped, the medications arrived in the afternoon of 12/12/24 and were administered as ordered. She confirmed it was odd for the hospital to send the hard prescriptions in a sealed envelope; she had not seen that before, but as soon as she was made aware the pharmacy did not have the two medications that needed the hard copy prescriptions, she immediately started addressing it so Resident #41 could have all of her medications in the facility. Interview with LPN #102 on 12/21/24 at 1:04 P.M. confirmed Resident #41 arrived to the facility on [DATE]. She confirmed she verified all the medications and orders from the hospital documentation with the physician and the pharmacy. She stated the pharmacy could not drop ship all of the medications because there were so many, so they would get them to the facility as soon as they could. She confirmed by the time she left on 12/12/24 at around 7:00 A.M., the medications had not arrived to the facility. Also, she confirmed she did not have a hard copy prescription for the Tizanidine or Oxycodone from the hospital, so she contacted the facility physician, who had the ability to send an electronic prescription to the pharmacy for them to be filled. She confirmed she did not follow up with the physician or pharmacy to ensure the prescription for Tizanidine and Oxycodone were filled; she assumed the physician had taken care of that. Interview with Resident #41 on 12/21/24 at 1:20 P.M. confirmed she was in pain due to not getting her Oxycodone medication when she needed it. She stated she didn't understand why the facility didn't have this medication in the facility already for her. She confirmed she got her Oxycodone in the afternoon on 12/12/24 and she had received it everyday since. She stated she had constant pain. She stated she was in pain due to not having the Oxycodone after she was discharged from the hospital on 12/11/24 into the afternoon on 12/12/24, but she could not say she was in any more pain than normal. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Nursing Admission Workflow for Admitting Nurse procedures, undated, revealed the staff tasked with a new resident admission should complete the following: print the Physician Orders Report, (located under the resident tab in the electronic medical records) for providers to sign, orders would be delivered to the pharmacy via the ePrescribe (electronic prescription) interface. Staff were to manually fax any controlled substances. This deficiency represents non-compliance investigated under Complaint Number OH00160656.