STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366298	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Nobles Pond, Inc	7006 Fulton Drive, NW Canton, OH 44718

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview, record review, self-reported incident (SRI) review, and facility policy review the facility failed to protect Residents #70, #22, #21, #64, #71 from misappropriation of narcotic medication. This affected five residents (#70, #22, #21, #64, #71) of the 29 residents who received narcotic medication. The facility census was 82. Findings include: 1. Review of the medical record for Resident #70 revealed an admitted [DATE] and was discharged from the facility on 04/13/24. Medical diagnoses included fracture of the neck of the left femur, aftercare following joint replacement, cardiomyopathy, atrial fibrillation, congestive heart failure, and severe protein calorie malnutrition. Review of Resident #70's physician orders dated 04/09/24 revealed an order to administer Oxycodone Hydrochloride (HCL) 5 milligrams (mg) (opioid pain medication) for severe pain every six hours as needed. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #70 required moderate assistance for bathing, lower body dressing, bed to chair transfers, and walking ten feet. Supervision was needed to roll left and right in bed, sit on side of bed, lie back in bed. Review of the medication administration record (MAR) revealed Resident #70 had received Oxycodone HCL two times for the five days the resident was in the facility. Review of pain assessment revealed Resident #70 had pain at a level of seven and ten on a scale from zero to ten, ten being the worst, on 04/10/24. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of SRI tracking number 246513 dated 04/18/24 revealed Resident #70's sister called the facility after discharge home regarding the oxycodone medication that was missing. On 04/17/24 the facility searched all the medication carts, medication rooms, nurse stations and nurse's offices showing no medication was found. All nurses were sent for a drug screen. On 04/18/24 the facility reported the incident to the Board of Pharmacy. On 04/18/24 the shred box was opened and searched for the missing narcotic card, and none was found, and all nurses drug testing came back negative. No discrepancies with drug counts were noted per nursing statements. The facility initiated a new shift change controlled medication count sheet accountability log on 04/18/24 with numbered pages to ensure no pages could be removed without noticing. Audits were done weekly. Education was provided titled Shift Change Controlled Medication Count Sheet Accountability Log. A witness statement dated 04/17/24 authored by Licensed Practical Nurse (LPN) #396 revealed they worked on 04/15/24 from 6:00 A.M. to 6:30 P.M. in the 500/600 hall. There were 16 controlled medication cards at the beginning of the shift, and she removed two empty cards during her shift. She did put 15 cards in at the start of her shift. She did not fill in the narcotic log at the beginning of the shift. She completed the log at the end of her shift. LPN #396 verified they did not look at the number above and did not notice the count was off. LPN #396 verified she changed the count to reflect 13 that the other nurse stated she had. LPN #396 verified they did not initial that on the sheet. LPN #396 verified she and the other nurse did not go back and review the count to ensure that it was correct. LPN #396 stated they marked the 13 and did not investigate further. LPN #396 did not remember what cards she removed during the shift. LPN #396 stated she started with 16 cards and only removed two cards; the count should have been 14. 2. Review of medical record for Resident #22 revealed an admitted [DATE]. Medical diagnoses included peripheral vascular disease, disruption of wound, severe protein calorie malnutrition, absence of left above the knee, and major depression. Review of Resident #22's physician order dated 05/28/24 revealed an order for Percocet Oxycodone HCL one tablet every six hours and Tramadol 50 mg (opioid pain medication) twice a day for chronic pain ordered 05/28/24. There was a physician order to assess pain twice a day. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #22's cognition was moderately impaired. Resident #22 needed two-person assistance for transfers from bed to chair, one person assistance for bed mobility, assistance for toilet hygiene. Review of pain assessment revealed Resident #22 had pain frequently. Review of SRI tracking number #246516 dated 04/18/24 revealed when the nurse went to reorder narcotic medication for Resident #22, the pharmacy stated it was too early to reorder, and insurance would not pay. The facility offered to pay for the medication. On 04/18/24, the pharmacy provided the facility with a copy of the packing slip for Resident #22, and it was signed by a nurse who no longer worked in the facility. The medication reconciliation report showed the narcotic medication was destroyed on 04/04/24. On 04/18/24, the facility contacted the pharmacy, and the pharmacy contacted the pharmacy board regarding the incident. The facility educated nursing staff regarding shift change medication count and accountability dated 04/18/24, 04/19/24, 04/20/24 and 04/21/24. Review of the nursing progress note dated 04/17/24 revealed Percocet tablet for Resident #22 was lost and theft was reported to pharmacy. The pharmacy did not have a suspect. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nursing witness statement by Registered Nurse RN #397 revealed on 04/18/24 the pharmacy provided the facility a copy of the packing slip proof of delivery for Resident #22 on the date of 03/25/24. On the slip dated 03/25/25, Resident #22 received three cards of 30 Percocet 5/325 mg tablets and one card of 26 Percocet 5/325 mg tablets that was signed by Nurse #398. The facility was unable to verify if Nurse #398 received all the medications due to the medication being missing. The pharmacy shift changes accounting record for the timeframe revealed staff members no longer worked at the facility. 3. Review of the medical record for Resident # 21 revealed an admitted [DATE]. Diagnoses included spinal stenosis, difficulty walking, muscle weakness, morbid obesity, bronchitis, and osteoarthritis. Review of the physician order dated 04/25/24 revealed an order to administer Oxycodone HCL 5/325 mg every six hours for severe pain. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #21 was cognitively intact. Resident #21 was dependent on staff to sit on the side of the bed, lie back in bed and roll from left to right in bed. Maximum assistance was needed for residents to stand from the bed, and from bed to chair transfers. Moderate assistance was needed to walk ten feet. Review of the MAR dated 05/01/24 to 05/14/24 revealed Resident # 21 received pain medication ten times. Review of pain assessment revealed Resident #21 had pain frequently from 05/01/24 to 05/14/24. Review of SRI tracking number 247556 dated 05/15/24 revealed LPN #309 verified she forgot to click off narcotic medication was given in the MAR. LPN #309 also verified she did not sign out the narcotic medication at the end of the shift. LPN #309 received a write up on 05/13/24 for policy violation related to medication administration and necessary documentation of resident status. 4. Review of medical record for Resident # 64 revealed an admitted [DATE]. Medical diagnoses included dementia, weakness, anemia, depression, failure to thrive, dorsalgia, and opioid dependence. Review of Resident #64's physician order dated 04/24/24 revealed an order to administer Oxycodone 5 mg two tablets every four hours as needed for pain. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #64 was cognitively intact and required extensive assistance from staff for bed mobility and transfers. Resident #64 was dependent on staff for showers. Review of the MAR dated 04/30/24 to 05/14/24 revealed Resident #64 received Oxycodone 18 times, and Resident #64 had pain frequently. Review of the Controlled Drug receipt Disposition form dated 04/30/24 to 05/14/24 revealed Resident #64 received oxycodone 35 times with some administrations not matching the MAR during the time frame. Review of SRI tracking number 247559 dated 05/15/24 revealed an incidental finding during medication audits. The facility found narcotic sheets were signed out for Resident #64 but not signed off in the MAR. Resident #64 did not have a change in condition or pain any more than usual. Staff education was provided to nursing staff. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of medical record for Resident #71 revealed an admitted [DATE] and a discharge date of [DATE]. Medical diagnoses included fracture of right humerus, fall, difficulty walking, osteoarthritis, and Charcot's foot. Review of Resident #71's physician order dated 05/13/24 revealed an order to administer Oxycodone HCL 5 mg every six hours as needed for pain. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #71's cognition was intact. Resident #71 was independent for self-care and needed maximum assistance for bathing. Supervision was needed to roll from left to right in bed and to sit on the side of the bed. Review of the MAR dated 05/13/24 to 05/25/25 revealed Resident #71 received oxycodone pain medication daily and had pain frequently. Review of SRI tracking number 247561 revealed on 05/10/24 the facility noticed LPN #309 wasted two narcotic medication that she said fell on the floor. LPN #309 stated RN #306 witnessed the waste. LPN # 309 also signed out narcotic medication on the disposition sheets but not the MAR. RN #306 denied witnessing LPN #309 waste narcotic medication on 05/10/24. Review of the witness statement dated 05/14/24 authored by LPN #309 revealed LPN #309 stated RN #306 wasted the pain medication for her. Review of LPN #309's personnel file revealed the Administrator filed a complaint with the Ohio Board of Nursing due to suspected drug diversion between the dates of 04/06/24 and 05/13/24. LPN #306 was terminated as of 05/13/24. Interview on 06/18/24 at 2:23 P.M. with RN #306 revealed he was being trained by LPN #309 on 05/10/24. RN #306 denied it was his signature on the narcotic sheet and stated LPN #306 signed his name that the medication was wasted. RN #306 verified the facility had educated staff in narcotic counting and wasting narcotics. Interview on 06/18/24 at 1:18 P.M. with the Director of Nursing (DON) revealed LPN #309 stated RN #306 was a witness to medication wasting. The previous DON did audits on all residents for pain and chart audits. It was stated at no time did a resident have a change in condition. New policies and procedures have been put in place with narcotic counting and receiving or narcotics from pharmacy. The facility has safeguarded the lock boxes and verified nursing staff was educated that two nurses were needed at all times to witness if narcotics are wasted. Interview on 06/18/24 at 2:07 P.M. revealed the Administrator called the police on 05/23/24 after additional SRI cases were opened up with incidental findings. The police were still investigating, and the Ohio Nursing Board had been called to report LPN #309. The Nursing Board was still investigating. Quality Assurance Improvement Projects have been implemented, education was provided, and updated policies and procedures were implemented. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/17/24 at 3:16 P.M. Narcotic count between the DON and LPN #313 revealed the 100/200 hall Narcotic count was a total of 28 medications, and the DON verified 28 medication packets were in the drawer. Morphine, Tramadol, Gabapentin, and Oxycodone were counted and verified by the LPN and DON. The DON repeated the pill count back after the LPN stated the pill count in the narcotic book. Review of the facility policy titled Abuse, Mistreatment, Neglect, Misappropriation of Resident Property and Exploitation, dated 2016, revealed the facility would not tolerate abuse, neglect, misappropriation of resident property or exploitation of its residents. Misappropriation of resident property was the deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's belongings or money without the resident consent. Review of the undated facility policy titled Medication Error Policy and Procedure revealed the facility strived to ensure medication were administered to each resident without complications. Medication error was defined as a medication error that was preventable and may cause or lead to inappropriate medication use or resident harm. The deficient practice was corrected on 05/23/24 when the facility implemented the following corrective actions: On 05/13/24 LPN #309 was suspended. On 05/14/24 a statement was obtained from LPN #309, and she consented to a drug screen. On 05/14/24 the DON completed narcotic accountability records on all medication carts. On 05/15/24 the Consulting Pharmacist was notified of the pending investigation. On 05/16/24 LPN #309 drug screen tested negative for oxycodone. On 05/17/24 the facility completed an Ad Hoc QAPI meeting. The Medical Director was in attendance. On 05/17/24 Resident #22 was interviewed related to pain by the facility with no negative findings. On 05/17/24 Resident #70 was interviewed related to pain by the nurse practitioner with no negative findings. On 05/17/24 Resident #21 was interviewed related to pain by the facility with no negative findings. On 05/17/24 Resident #64 was interviewed related to pain with no negative findings. On 05/17/24 Resident #71 was interviewed related to pain with no negative findings. None of the affected residents (# 22, #70, #21, #64 and # 71) needed an order for a urine drug screen because no resident had complained of pain during the interviews conducted on 05/17/24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/17/24 Resident #22 was made aware of the investigation and did not want her responsible party notified. On 05/17/24 Resident # 70 was made aware of the investigation and responsible party was notified. On 05/17/24 Resident # 21 was made aware of the investigation and responsible party was notified. On 05/17/24 Resident # 64 was notified of the investigation and responsible party was notified. On 05/17/24 Resident # 71 was notified of the investigation and responsible party was notified. From 05/15/24 to 05/22/24 all residents with narcotic pain medication were interviewed related to pain management and receipt of medication with no negative findings. From 05/15/24 to 05/22/24 all current residents had pain assessments completed by licensed nurses with no negative findings. From 05/16/24 to 05/22/24 the Administrator and DON educated all the staff on Abuse, Neglect and Misappropriation policy and reporting, staff not on duty were educated by phone, those that were unable to be reached were educated prior to the next shift. All newly hired staff will be educated on said process during orientation. From 05/16/24 to 05/22/24 the DON/Designee educated all licensed nurses on Drug Diversion, Narcotic reconciliation process, Pain management, Narcotic destruction and Medication Administration. Staff not on duty was educated by phone and staff not able to be reached was educated prior to oncoming shift. All hired licensed nursed will be educated on said process during orientation. Beginning 05/22/24, the DON/Designee will audit Narcotic Count on medication carts twice per week for four weeks then ongoing monthly to ensure narcotic accountability is properly completed. Beginning 05/22/24 the DON/Designee will audit narcotic accountability records twice a week for four weeks then monthly times two months to ensure any as needed controlled medication administered are documented properly and the resident validated receipt of said medication. Beginning 05/22/24 the DON/Designee will audit MARs twice a week for four weeks then monthly for two months to ensure medication was administered per order. Beginning 05/22/24 the DON/ will audit nurse if able to verbalize proper procedure to narcotic destruction twice a week for four weeks, then monthly for two months to ensure proper procedure for narcotic destruction. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. On 05/23/24 the local police were notified and requested to be contacted when the investigation was complete. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/23/24 the Ohio Board of Nursing was emailed, faxed and called informing of the suspension of LPN #309. On 06/03/24 LPN #309 was terminated. This deficiency represents non-compliance under Self-Reported Incident Control Number OH00154329.