| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366298 | A. Building<br>B. Wing | 03/19/2026 |

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| Altercare of Nobles Pond, Inc | 7006 Fulton Drive, NW<br>Canton, OH 44718 |

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) |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure the responsible party was notified of a medication change. This affected one resident (Resident #4) of five residents reviewed for unnecessary medications. The facility census was 61.Findings include:Resident #4 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, peripheral vascular disease, a urinary tract infection, calculus of the kidney, and osteonecrosis to the left femur from a previous trauma. Review of Resident #4's admission psychiatric evaluation on 03/04/26 by Medical Doctor (MD) #950, the facility's consulting psychiatrist, revealed the resident reported feeling sad and depressed, complaints of not sleeping, feeling anxious and restless as he is not able to do things. MD #950 diagnosed Resident #4 with Generalized Anxiety Disorder and added BuSpar (an antianxiety medication) 10 milligrams (mg) orally twice a day to treat it.Review of the nursing progress notes from 02/27/26 to 03/05/26 for Resident #4 revealed no documentation regarding MD #950's assessment on 03/04/26. There was no documentation of the resident's responsible party being notified of the new order for BuSpar. On 03/06/26 at 3:42 P.M, the DON documented she had spoken with the family and they requested the order for BuSpar be discontinued. Review of Resident #4's Medication Administration Record (MAR) for March 2026 revealed the order for BuSpar was entered on 03/05/26. The resident received his first dose on 03/05/26 between 6:30 P.M. and 10:30 P.M. The second dose was administered on 03/06/26 between 6:30 A.M. and 10:30 A.M.Interview with Resident #4's responsible party (RP) on 03/17/26 at 3:30 P.M. revealed the facility started the resident on BuSpar 10 mg orally twice a day for an unknown reason as well as Trazodone 25 mg orally every evening. The RP stated Resident #4 has had adverse reactions to psychotropic medications in the past and did not want him on anything that crosses the blood brain barrier. She did not know the facility had started him on the medication until she went in to visit and the nurse told her about it. The RP requested the medication be discontinued.Interview with the ADON #603 on 03/18/26 at 4:30 P.M. revealed ADON #603 was given an order for BuSpar as MD #950 had completed his admission psychiatric evaluation. ADON #603 said she gave the order to ADON #524 was on the phone with the responsible party (RP)for Resident #4 and informed her of the new order. The following day the RP for Resident #4 came to the facility with her two children and met with ADON #603 in her office and spoke with the RP for about an hour regarding the BuSpar order. The RP informed ADON #603 she did not want Resident #4 to take the BuSpar due to the potential side effects of the medication. ADON #603 said the resident received two doses before it was discontinued.Interview with ADON #524 on 03/19/26 at 11:35 A.M. revealed she did not notify Resident #4's family over the phone regarding the addition of BuSpar to the resident's medication. ADON #524 said all communication with the RP was in person, not over the phone. She spoke with the RP daily. ADON #524 said she received the order for BuSpar and discussed it with the RP the next day she visited. The RP said she did not want Resident #4 to be on it and requested it not be given. ADON #524 notified the nurse practitioner when she next her. ADON #524 said she did not believe Resident #4 received any doses of the medication.Review of the facility's Change in the Resident's Condition or Status policy, last revised 05/01/25, revealed the nurse is to immediately notify the resident, consult with the resident's attending physician, on call<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | physician, nurse practitioner, physician assistant or clinical nurse specialist, and notify the resident's authorized representative when there is a change in the mental, physical, or psychosocial status. This information must be documented in the resident's medical record. This deficiency represents noncompliance investigated under Complaint Number 2807084. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on interview, observation, and record review, the facility failed to ensure a clean and homelike environment was maintained for Resident #58. This affected one resident (#58) of 61 residents screened for environmental concerns. The facility census was 61.Findings include:Review of Resident #58's medical record revealed an admission date of 11/04/25. Diagnoses include but not limited to the need for personal care, difficulty walking, muscle weakness, and repeated falls.Review of Resident #58's care plan dated 01/21/26 revealed the resident had an impaired ability to perform or participate in daily ADL care. Interventions included to assist with toileting if needed and provide incontinence care as needed. Interview and observation on 03/16/2026 at 11:40 A.M. with Resident #58 revealed her bedpan smelled terrible and staff did not clean the bedpan after use. During the interview, two unlabeled and unbagged orange bedpans were observed in the bathroom. One bedpan was inside the toilet bowl and one bedpan was on the floor between the wall and toilet. Both bedpans appeared to have barrier cream residue on them. Interview on 03/16/26 at 11:42 A.M. with Certified Nursing Assistant (CNA) #615 confirmed the two bedpans were stored inappropriately. Review of the facility's resident rights policy, dated 05/01/25, our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. This deficiency represents non-compliance investigated under Complaint Number 2807084. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure Resident #4 was provided appropriate medical treatment in response to a change in condition. Additionally, the facility failed to ensure appropriate wound care and services were provided to Resident #24 and Resident #95. Additionally, the facility failed to ensure daily weights were obtained as ordered for Resident #76. This affected four residents (#4, #24, #76, and #95) of 25 residents reviewed for quality of care and treatment. The facility census was 61. Findings include:1.Review of Resident #4's medical record revealed the resident was admitted on [DATE] with diagnoses including acute kidney failure, calculus of the kidney and urinary tract infection.<br><br>Review of Resident #4's physician orders revealed an order dated 02/27/26 for Eliquis (an oral anticoagulant medication) 2.5 milligrams (mg) twice daily.<br><br>Review of Resident #4's physician orders revealed an order dated 02/28/26 for catheter care twice a day from 6:00 A.M. to 6:00 P.M. and 6:00 P.M. to 6:00 A.M. Resident #4 also had an order dated 03/02/26 to irrigate the resident's Foley (indwelling urinary) catheter one time for a diagnosis of hematuria. The MAR and TAR indicated this was completed.<br><br>Review of Resident #4's Office Visit Note dated 03/03/26 at 10:28 A.M. authored by Urologist #622 revealed the resident had urinary retention and a Foley catheter was inserted for 900 cubic centimeters (cc) of urine. An order would be put in to remove the Foley catheter for a voiding trial.<br><br>Review of Resident #4's lab results dated 03/03/26 at 6:15 P.M. revealed the red blood cell count (RBC) and hemoglobin (HGB) were 8.3 and 26.3 (normal was 14.0 to 18.0 for RBC and 42.0 to 54.0 on HGB).<br><br>Review of Resident #4's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.<br><br>Review of Resident #4's Resident Progress Note dated 03/05/26 at 2:07 P.M. authored by Registered Nurse (RN) Assistant Director of Nursing (ADON) #524 revealed the Nurse Practitioner (NP) spoke to the urology's office regarding the Foley and voiding trial the family was asking about. The NP stated urology wanted to wait until the stents were removed to remove the Foley and try a voiding trial.Review of Resident #4's Physician Progress Note authored by the Medical Director dated 03/09/26 revealed the [AGE] year-old male with a past medical history significant for hyperlipidemia, anemia, and chronic left hip pain who was receiving skilled therapies. The resident had benign prostatic hypertrophy (BPH) with urinary retention, and a Foley catheter was placed during hospitalization. The resident was noted with hematuria on 03/02/26 and moderate sized blood clots and thick mucous sediment on 03/05/26. A urinalysis was ordered and staff to notify Urologist #622. Per the urology department, the Foley to remain in place until stents were removed and then attempt a voiding trial.<br><br>Review of Resident #4's lab results dated 03/10/26 at 4:23 P.M. revealed the RBC was 9.6 and the HGB was 29.6.<br><br>Review of Resident #4's NP progress note dated 03/12/26 revealed the resident was disoriented and continued to have blood clots and mucous in catheter. Concerns were identified for a urinary tract (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | infection (UTI). A physical exam revealed a moderate amount of blood clots.<br><br>Review of Resident #4's progress note dated 03/14/26 at 3:25 A.M. authored by RN #620 revealed the resident was having large blood clots with urination and some bloody drainage from the end of his penis. A message was left for the NP on call to address. The medical record did not have evidence Resident #4's family were notified per the medical record and the note did not have evidence the NP returned the call to address the concerns.<br><br>Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated March 2026 revealed nursing staff documented catheter care on 03/13/26 on both shifts, 03/14/26 on both shifts, and 03/15/26 on both shifts.<br><br>Review of Resident #4's progress note dated 03/14/26 at 11:50 A.M. authored by RN #581 revealed the resident was having large amounts of bloody urine and no complaints voiced. The NP was paged per the medical record but the medical record did not have evidence Resident #4's family members were notified per the medical record.<br><br>Review of Resident #4's lab result form dated 03/14/26 at 12:56 P.M. revealed the RBC was 7.2 and the HGB 24.5.<br><br>Review of Resident #4's progress note dated 03/14/26 at 1:46 P.M. authored by RN #581 revealed the NP gave new orders for an immediate complete blood count (CBC) and to notify Urologist #622 of the bleeding.<br><br>Review of Resident #4's progress note dated 03/14/26 at 1:47 P.M. revealed Urologist #622 was notified of the bleeding at this time and stated the bleeding was still normal and to monitor for blood clots.<br><br>Review of Resident #4's progress note dated 03/15/26 at 2:41 A.M. revealed the immediate CBC results came back and the NP was notified. The facility was waiting on orders for a RBC of 7.2 and a HBG of 24.5. The medical record did not have evidence the family members were notified of the results of the bloodwork.<br><br>Review of Resident#4's MARS revealed the resident's Eliquis was due from 6:30 A.M. to 10:30 A.M. (morning) and 6:30 P.M. to 10:30 P.M. (evening). The MARS confirmed the resident received the Eliquis anticoagulant for both shifts on 03/10/26; held for the morning administration on 03/12/26 and administered for the evening administration of 03/12/26; administered on 03/13/26 both shifts; administered on 03/14/26 both shifts; administered on 03/15/26 both shifts; administered on 03/16/26 morning shift.Review of Resident #4's progress note dated 03/16/26 at 3:32 P.M. authored by the Director of Nursing (DON) revealed the NP was contacted regarding the resident's hematuria. New orders were obtained to hold the Eliquis anticoagulant for three days and an immediate CBC. The note also stated to call the urologist. Urologist #622 was called and the family and resident were notified of new orders.Review of Resident #4's progress note dated 03/16/26 at 4:19 P.M. authored by RN ADON #524 revealed Urologist #622 returned call and was notified of HGB of 7.2 and bleeding from the penis. Eliquis was to be held for three days and repeat CBC.Review of Resident #4's lab results dated 03/16/26 at 8:04 P.M. revealed the RBC was 5.6 and the HGB was 18.3.Review of Resident #4's progress note dated 03/16/26 at 10:24 P.M. revealed a new HGB of 5.6 and the NP ordered for the resident to be sent to the emergency room. The family were notified and thankful for the update.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #4's ED Provider Note dated 03/16/26 at 11:38 P.M. authored by Physician #625 revealed the resident came to the ED via EMS from the SNF. The resident stated that he had been experiencing a bleeding penis for the past few days. The resident had a hemoglobin of 5.6. According to the EMS, the resident had been experiencing bleeding from his penis for the last few days. EMS stated that the SNF had completed a hemoglobin level on the resident and it was 5.6 hence the reason for the ED visit. The resident's skin color was pale. Blood was noted coming from the penile meatus.<br><br>Review of Resident #4's hospital history and physical note dated 03/17/26 at 5:36 A.M. authored by Physician #624 revealed the resident was admitted on [DATE] and the resident was a [AGE] year-old male who presented from the SNF with bleeding from his penis. EMS was called for abnormal labs; however, when EMS arrived, there was no copy of the blood work. The resident was noted to have hematuria. The resident's hemoglobin was 5 and two units of packed red blood cells were provided. A CT of the abdomen and pelvis without contrast revealed dense fluid in the urinary bladder with foci of internal gas, possibly a clot, bilateral staghorn calculi, mild right hydroureter and inflammatory changes surrounding the left ureter. An ascending infection was considered. Started on continuous irrigation and ceftriaxone was administered. Chart review revealed the resident was status post (s/p) cystoscopy with the removal of a foreign body calculus, ureteral stent from urethra or bladder on 03/12/26 by Urologist #622 and the urine culture on 03/05/26 was positive for pseudomonas. Antibiotics were ordered. No paperwork was provided from the nursing facility.Review of Resident #4's progress note dated 03/17/26 at 8:10 A.M. revealed the resident was admitted to the hospital with a diagnosis of gross hematuria.Review of Resident #4's hospital documentation dated 03/17/26 at 8:59 A.M. authored by CNP #623 revealed the key findings of the assessment revealed gross hematuria, clot retention, acute blood loss anemia, acute, complicated diagnosis of hematuria including UTI, BPH exacerbated by anticoagulation. Large amount of clot removed from the bladder and the hematuria was currently mild.<br><br>Telephone interview with NP #621 on 03/17/26 at 3:27 P.M. revealed she had reviewed the NP call logs, and the facility notified their agency early in the morning (of 03/14/26) for the hemoglobin of 7.2 and no new orders were provided to the facility. NP #621 reported she had reviewed the NP call logs for the dayshift on-call person on 03/14/26 (no time specified) and the on-call staff member gave an order to contact urology for blood clots. NP #621 confirmed their protocol was to call facilities within 20 minutes and there was an escalation protocol. NP #621 confirmed their call logs did not have exact times and only shifts due to the large volume of calls to their agency.Interview on 03/17/26 at 12:42 P.M. with RN ADON #603 revealed the facility sent Resident #4 to the ED due to a low hemoglobin level. When questioned as to why it took approximately eight hours and twenty-five minutes for the NP to respond to a change in condition from 03/14/26 at 3:25 A.M. to 03/14/26 at 1:46 P.M., she stated the resident did not have a change in vitals and she felt it was appropriate.Interview on 03/17/26 at 1:50 P.M. with the Director of Nursing (DON) revealed approximately eight hours and twenty-five minutes was not a timely notification of blood clots from the resident's penis. She stated 10 hours was too late to address a change in condition. Interview on 03/17/26 at 2:05 P.M. with Regional RN #619 revealed eight hours and twenty-five minutes was a long time to wait for a change in condition, but she felt the HGB level of 7.2 was stable and it was not harmful.Telephone interview on 03/17/26 at 4:01 P.M. with Resident #4's family member revealed she had previously voiced concerns about the resident's care and the bleeding from the penis to the DON.Telephone interview on 03/18/26 at 9:22 A.M. with Urologist #622 revealed he had assessed Resident #4 on 03/03/26 and placed an order to remove the Foley catheter. He stated on 03/05/26, he received a message from the NP reporting bleeding from the resident's penis, and he decided to leave the Foley catheter in place until the stents were removed on 03/12/26. He stated he was aware the resident was bleeding and on Eliquis and stated the facility's NP and Physician were covering and monitoring the resident.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Telephone interview on 03/18/26 at 12:05 P.M. with Medical Director (MD) #627 revealed he had discussed the bleeding and Eliquis with Resident #4's family, the cardiologist, and the urologist. MD #627 revealed the resident's bloodwork was monitored and there was not a significant drop in the resident's RBC or HGB levels. He stated the hospital documents wanted the resident to stay on the Eliquis anticoagulant unless the resident's condition deteriorated and reported the resident's RBC hovered around 7.3 to 8.3. MD #627 revealed he had assessed the resident on 03/09/26 and everything was clear and he did not identify bleeding, but he was aware the resident had bleeding on and off.<br><br>Review of the Change in a Resident's Condition policy updated 05/01/25 revealed it was the policy to ensure the resident's attending physician and the resident's authorized representative or interested family member were notified in the resident's physical, mental, or psychosocial status.<br><br>2. Review of Resident #95's medical record revealed the resident was admitted on [DATE] with diagnoses including displaced fracture of the right femur, aftercare following joint replacement surgery and pleural effusion.<br><br>Review of Resident #95's X-ray dated 03/05/26 (completed prior to admission to the facility) revealed the resident had interval placement of the right hip arthroplasty which was in near anatomic alignment.<br><br>Review of Resident #95's care plans did not reveal care plans and interventions for the resident's right surgical hip dressing.<br><br>Observation on 03/16/26 at 1:09 P.M. revealed the resident had a dressing to the right hip and no orders for wound care.<br><br>Interview on 03/19/26 at 11:27 A.M. with the DON confirmed the resident did not have orders or a care plan for wound care and interventions for the resident's right hip.<br><br>3. Review of the medical record for Resident #24 revealed an admission date of 11/25/25. Diagnoses included but not limited to an encounter for surgical aftercare following surgery on the digestive system, muscle weakness, need for assistance with personal care, and malignant neoplasm of the liver and colon.<br><br>Review of Resident #24's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #24 had one stage four pressure ulcer and no evidence of a skin tear to her left thigh.<br><br>Review of Resident #24's physician orders did not reveal evidence of assessments and treatments to the left posterior inner thigh skin tear.<br><br>Observations on 03/18/26 at 2:20 P.M. with Regional RN #628 and RN #514 of Resident #24's sacrum wound care revealed no concerns. However, the resident had a wound dressing on the left posterior inner thigh which was dated 03/15/26. Interview on 03/18/26 at 3:14 P.M. with the DON confirmed Resident #24 had a skin tear on the left posterior inner thigh signed off by Licensed Practical Nurse (LPN) #564 and the medical record did contain documentation of or orders to treat the skin tear.<br><br>Review of the facility's wound care policy, dated 05/01/25, revealed wound care was provided using professional standards of practice. The police instructed staff to review the resident's care plan to<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | assess for any special needs. Also, verify there was a physician order for the procedure.<br><br>4. Review of the medical record or Resident #76 revealed an admission date of 10/23/24. Diagnoses included but were not limited to unilateral primary osteoarthritis, morbid obesity, type II diabetes mellitus and irritable bowel syndrome.<br><br>Review of the physician orders for Resident #76 revealed an order dated 02/06/26 for daily weights to be obtained.<br><br>Review of the 02/13/26 admission Minimum Data Set (MDS) 3.0 for Resident #76 revealed a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. Resident #76 was noted to require set-up assistance for meals and was also noted to receive a diuretic medication.<br><br>Review of the 02/18/26 care plan for Resident #76 revealed the resident would maintain daily routine without chest pain or cardiac complications. Interventions included observing for any edema (swelling) of pedal, and lower extremities, and obtaining vital signs as ordered and as needed.<br><br>Review of the daily weights recorded on the TAR for February 2026 for Resident #76 revealed a daily weight was not obtained on 02/06/26, 02/22/26, 02/23/26, and 02/24/26. Out of 23 ordered daily weights, four daily weights were not obtained as physician ordered for Resident #76.<br><br>Review of the daily weights recorded on the TAR for March 2026 for Resident #76 revealed a daily weight was not obtained on 03/08/26, 03/12/26 and 03/16/26. Out of 18 ordered daily weights, three daily weights were not obtained as physician ordered for Resident #76.<br><br>Review of progress notes from 02/01/26 to 03/19/26 for Resident #76 revealed no evidence related to why daily weights were not being completed as ordered.<br><br>Interview on 03/19/26 at 10:33 A.M. with LPN #586 confirmed Resident #76 had an order for daily weights and some of the required daily weights had not been completed as ordered.<br><br>Review of the facility policy Weight/Reweigh Policy dated 05/01/25 revealed a resident's weight will be monitored to evaluate the resident's nutrition status, within the parameters of the resident's overall medical condition. A resident's weight will be obtained and recorded in the electronic medical record (EMR) by the nursing staff.<br><br>This deficiency represents non-compliance investigated under Complaint Numbers 2807084 and 2786114. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate care and treatment was provided for Residents #4 and #24's pressure ulcers. This affected two residents (#4 and #24) of two residents reviewed for pressure ulcers. The facility census was 61.Findings Include:1. Resident #4 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, peripheral vascular disease, a urinary tract infection, calculus of the kidney, and osteonecrosis to the left femur from a previous trauma.<br><br>Review of the admission Assessment and Baseline Care Plan for Resident, dated 02/27/26 and completed by Licensed Practical Nurse (LPN) #588, revealed the resident did have a wound but the location was not documented. The Baseline Care Plan revealed a care plan for wound care was initiated.<br><br>Review of the nursing progress notes from 02/27/26 through 03/17/26 revealed no documentation regarding Resident #4 having any wounds.<br><br>Review of the physician's orders for Resident #4 revealed there were no orders for wound care.<br><br>Interview with the Responsible Party (RP) for Resident #4 on 03/17/26 at 3:30 P.M. revealed the resident did have pressure wounds to his buttocks. The RP provided a photo of the wound she photographed on 03/08/26 showing two open areas to the left and right of the gluteal fold. The area was reddened. The RP stated the facility was not providing wound care for it.<br><br>Review of the nursing documentation from Resident #4's urology office, dated 03/12/26 at 1:36 P.M., revealed Urology Registered Nurse (RN) #632 documented Patient came to OR with 2 open skin areas on his left medial buttock area. He also has a stage 1 pressure ulcer on his coccyx. The resident was at the office to have ureteral stents removed.<br><br>Interview with Resident #4's Family Member #901, on 03/17/26 at 10:51 A.M. revealed she was present in the room when the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #603 entered the room to complete a skin check on the resident. Family Member #901 was present during the skin assessment and observed a round red area to the resident's buttock with yellow slough present.<br><br>Review of the Initial Wound Grid Documentation 8.9 for Resident #4, dated 03/03/26, was completed by Assistant Director of Nursing (ADON) #603. The only wound documented was a skin tear to the resident's right arm. No other wounds were noted.<br><br>Interview with Regional Registered Nurse (RRN) #619 on 03/18/26 at 2:00 P.M. revealed the skin tear present upon admission was the only wound Resident #4 had during his stay. RRN #619 said she had spoken with ADON #603, who was also the facility's wound nurse, who said she had provided incontinence care for Resident #4 on 03/16/26 with the assistance of an unknown aide and ADON #603 denied the resident had any wounds to his buttocks. RRN #619 could not identify who the aide was assisting ADON #603 with incontinence care. A second interview with RRN #619 at 3:30 P.M. revealed she had spoken with all nurses, the DON, ADON #603, and the nurse aides and no one reported seeing a wound to Resident #4's buttocks.<br>(continued on next page) |

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| | 366298 | A. Building<br>B. Wing | 03/19/2026 |

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| Altercare of Nobles Pond, Inc | 7006 Fulton Drive, NW<br>Canton, OH 44718 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with RRN #619 on 03/19/26 at 8:50 A.M. confirmed the urology nurse documented Resident #4 had wounds to his buttocks on 03/12/26. RRN #619 said no orders were provided by the urologist, Medical Doctor (MD) #622, with the resident's discharge orders.<br><br>Interview with the DON, ADON #603, and ADON #524 on 03/19/26 at 1:35 P.M. revealed all denied Resident #4 had any wounds other than the skin tear to the resident's left arm.<br><br>2. Review of the medical record for Resident #24 revealed an admission date of 11/25/25. Diagnoses included but not limited to an encounter for surgical aftercare following surgery on the digestive system, muscle weakness, need for assistance with personal care, and malignant neoplasm of the liver and colon.<br><br>Review of Resident #24's care plan dated 12/04/25 revealed a pressure injury to the sacrum due to impaired mobility, urinary incontinence, and cancer. Interventions included performing treatment as ordered, reporting non-compliance, observing the wound, and complete preventative measures.<br><br>Review of Resident #24's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #24 was cognitively intact, needed supervision or touch assistance for rolling left to right, frequently incontinent of urine, had a colostomy in place, and one stage four pressure ulcer.<br><br>Review of Resident #24's physician orders revealed an order for the sacrum to be cleansed with soap and water, pat dry, gently fill Aquacel AG (a sterile, antimicrobial dressing used to manage moderate-to-highly exudating wounds) rope into the wound and undermining, then apply foam dressing every other day and PRN.<br><br>Review of Resident #24's Treatment Administration Record (TAR) for February 2026 revealed the resident's sacral wound treatment was not recorded as completed on 02/17/26, 02/21/26, and 02/22/26.<br><br>Review of Resident #24's TAR for March 2026 revealed the resident's sacral wound treatment was not recorded as completed on 03/02/26, 03/05/26, and 03/08/26.<br><br>Interview on 03/17/26 at 8:29 A.M. with Resident #24 indicated the facility was not consistently changing her sacral wound dressing. Resident #24 was not aware of whether the wound developed in the facility or in the hospital but indicated it occurred from not being repositioned. A follow up interview on 03/17/26 at 1:06 P.M. with Resident #24 indicated only two nurses in the facility regularly changed her sacral dressing.<br><br>Interview on 03/17/26 at 4:25 P.M. with RRN #619 verified the missing TAR entries for Resident #24's sacral wound pressure ulcer treatment.<br><br>Interview on 03/17/26 at 4:06 P.M. with ADON #603 indicated an outside wound center managed Resident #24's sacral wound care. ADON #603 indicated the wound center recently changed her treatment frequency, possibly to ensure the treatment would be completed. ADON#603 indicated Resident#24 was normally compliant with treatment. ADON #603 was unaware of treatments not being completed but indicated it could have been an issue with agency nursing staff usage.<br><br>Review of the facility's Wound Care-Clean Technique policy, last revised 05/01/25, revealed it was the facility's policy to provide wound care to residents using professional standards of practice.<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This deficiency represents non-compliance investigated under Complaint Numbers 2807084 and 2786114. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure Resident #4 received appropriate care and services to manage the resident's pain. This finding affected one (Resident #4) of four residents reviewed for medication administration. The facility census was 61.Findings include:Review of Resident #4's medical record revealed the resident was admitted on [DATE] with diagnoses including acute kidney failure, calculus of the kidney, and urinary tract infection.Review of Resident #4's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #4's physician orders revealed an order dated 02/27/26 for Acetaminophen (a mild over-the-counter pain reliever and fever reducer) 325 milligrams (mg) orally every four hours as needed for pain. The medication was discontinued on 03/03/26. Resident #4 also had an order dated 03/03/26 for Oxycodone (a narcotic analgesic) 2.5 mg orally every eight hours as needed for pain. Review of Resident #4's Medication Administration Records (MAR) for March 2026 revealed on 03/02/26, the resident was administered a Tylenol at 11:07 A.M. for a pain level of six which was not effective and a Tylenol at 2:42 P.M. which was effective.Review of an Orthopedic Note dated 03/09/26 authored by Orthopedic Physician #626 revealed the [AGE] year-old male presented with a complaint of primary osteoarthritis of the left hip. The resident was from a skilled nursing facility (SNF) and had been hospitalized and in a facility since 01/2026 due to multiple medical issues. He had a catheter in place due to urinary retention and kidney stones. The orthopedic note indicated they were unclear how ambulatory the resident was and the history was provided by the daughter-in-law (DIL). The resident stated he had left hip pain. A discussion was held that the catheter needed to be removed and had to have dental clearance prior to proceeding with a left total hip arthroplasty (THA) utilizing a posterior approach. He was to see a urologist to discuss the catheter and stents that were being removed. Review of Resident #4's Oxycodone Controlled Drug Receipt Disposition Form revealed the resident received Oxycodone 2.5 mg on 03/16/26 at 4:30 A.M.Observation and interview on 03/16/2026 at 11:31 A.M. with Resident #4 revealed he was hurting all over, including his arms, legs and teeth.Review of Resident #4's progress note dated 03/16/26 at 12:02 P.M. authored by Registered Nurse (RN) Assistant Director of Nursing (ADON) #524 revealed the resident was yelling out and stated his pain was a 9 out of 10. Narcotics were not due. Tylenol was administered and the NP was notified.Review of Resident #4's progress note dated 03/16/26 at 12:19 P.M. authored by RN ADON #524 revealed the provider ordered Oxycodone 5 mg every eight hours as needed for pain and a dose was administered.Review of Resident #4's Oxycodone Controlled Drug Receipt Disposition form revealed the resident received 5 mg of Oxycodone (two, 2.5 mg tabs) on 03/16/26 at 12:32 P.M.Review of Resident #4's MARS revealed on 03/16/26 at 2:20 P.M., the Oxycodone was effective and the resident was resting.Observation on 03/16/26 at 2:39 P.M. revealed Resident #4 was in bed yelling out that he was in pain. During a telephone interview on 03/17/26 at 3:17 p.m. with NP #621, the NP revealed she was aware of Resident #4's pain concerns on 03/16/26 around 12:00 P.M. and she had ordered an increase in the Oxycodone pain medication for the resident. NP #621 indicated that the family felt too many narcotics would make the resident more confused and she had raised the narcotic to manage the resident's pain.Telephone interview on 03/17/26 at 4:01 P.M. with Resident #4's DIL revealed she had voiced concerns about the resident's care, including pain control.Interview on 03/18/26 at 10:12 A.M. with RN ADON #603 revealed Resident #4 was resting following the Oxycodone narcotic administration on 03/16/26 around 2:20 P.M. and she did not hear the resident if he hollered out.Telephone interview on 03/19/26 at 12:50 P.M. with Resident #4's family member who visited the resident on 03/02/26, revealed she had to find staff members to assist the resident and provide the resident pain medications. Resident #4's family member stated the resident was screaming in pain on 03/02/26 and was told that the Tylenol would not be available for another 40 minutes. Resident #4's<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | family member revealed Licensed Practical Nurse (LPN) #635 was the nurse and the nurse stated the NP would not be in until 03/03/26 and she would not address the resident's pain. Resident #4's family member stated the nurse would not call the physician and the resident was in pain.Telephone interview on 03/19/26 at 1:23 P.M. with LPN #635 revealed she was aware Resident #4's family had come to her and told her the resident needed pain medication. LPN #635 revealed the family wanted her to call the NP and she told them the NP would be at the facility the next day. She did not remember if the resident hollered out in pain and stated she gave the resident a Tylenol. LPN #635 confirmed the NP wanted to see resident's in person for narcotic pain medication and that was why she did not call the NP but she did leave a message in the log book for the physician.Review of the Change in a Resident's Condition policy updated 05/01/25 revealed it was the policy to ensure the resident's attending physician and the resident's authorized representative or interested family member were notified in the resident's physical, mental, or psychosocial status.Review of the Pain Medication Administration policy revised 05/01/25 revealed it was the facility policy to administer pain medications in accordance with professional standards of practice.This deficiency represents non-compliance investigated under Complaint Number 2807084. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>Based on review of medical record, interview, and facility policy review, the facility failed to ensure pharmacy recommendations were implemented timely. This affected one (Resident #5) of five residents reviewed for unnecessary medications. The facility census was 61.Findings include:<br>Review of the medical record for Resident #5 indicated an admission date of 12/06/25. Diagnoses included but were not limited to a displaced fracture of upper end of right humerus, abnormalities of gait and mobility, type II diabetes mellitus, morbid obesity and chronic kidney disease.Review of the 01/13/26 five-day admission Minimum Data Set (MDS) 3.0 for Resident #5 indicated a Brief Interview of Mental Status (BIMS) of 10 which indicated moderate cognitive impairment. Resident #5 was noted to be receiving diuretic, opioid, antiplatelet, and antidepressant.Review of the physician order dated 01/27/26 for Resident #5 revealed an order for 25 milligram (mg) capsule of Hydroxyzine Pamoate (a prescription antihistamine used to treat anxiety and itching) 25 milligrams (mg) to be given orally one time per day as needed. The order was noted to be discontinued on 03/16/26.Review of the 02/16/26 pharmacy recommendations for Resident #5 revealed recommendations to discontinue Hydroxyzine Pamoate 25 milligram (mg. The physician reviewed the recommendation and recommended discontinuation of Hydroxyzine Pamoate on 02/20/26. Review of the Medication Administration Record (MAR) dated February 2026 for Resident #5 revealed an order for a Hydroxyzine Pamoate 25 mg capsule to be given orally one time per day as needed. It was noted to be administered on 02/25/26.Review of the MAR dated March 2026 for Resident #5 revealed an order for a Hydroxyzine Pamoate 25 mg capsule to be given orally one time per day as needed. The medication was noted to be given on 03/06/26 and 03/11/26.Interview on 03/17/26 with Regional Nurse #619 confirmed the 02/16/26 pharmacy recommendation was to discontinue Hydroxyzine Pamoate, the physician signed to discontinue the medication on 02/20/26, but the medication continued to be administered on 02/25/26, 03/06/26, and 03/11/26, and the order was not discontinued until 03/16/26. Review of the May 2020 facility policy titled Preparation and General Guidelines revealed under section B. Administration number (2) Medications are administered in accordance with orders of the prescriber(s).This deficiency represents noncompliance investigated under Complaint Number 2807084. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure residents medication regimens had an appropriate indication for use. This affected one resident (Resident #4) of five residents reviewed for unnecessary medications. The facility census was 61.Findings include:Resident #4 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, peripheral vascular disease, a urinary tract infection, calculus of the kidney, and osteonecrosis to the left femur from a previous trauma. Resident #4's medical record did not include diagnoses of generalized anxiety disorder, depression, or any psychiatric conditions. Review of Resident #4's progress notes from 02/27/26 through 03/04/26 revealed no indication or record of Resident #4 exhibiting any signs or symptoms of anxiety. There was no documentation of Resident #4 being referred to the facility's psychiatric services. Review of Resident #4's admission psychiatric evaluation on 03/04/26 by Medical Doctor (MD) #950, the facility's consulting psychiatrist, revealed the resident reported feeling sad and depressed, complaints of not sleeping, feeling anxious and restless as he is not able to do things. MD #950 diagnosed Resident #4 with Generalized Anxiety Disorder and added BuSpar (an antianxiety medication) 10 milligrams (mg) orally twice a day to treat it and Trazodone 25 mg orally every evening for depression. The note indicated depression was being ruled out and did not list depression as a new diagnosis. Review of the nursing progress notes for Resident #4 revealed no documentation on 03/04/26 regarding MD #950's assessment and order for BuSpar 10 mg twice a day for anxiety or Trazodone 25 mg every evening for depression. There was no documentation noted regarding the initial order for BuSpar or notification of Resident #4's responsible party. On 03/06/26 at 3:42 P.M., the DON documented she had spoken with the family and they requested the order for BuSpar be discontinued. Review of Resident #4's Medication Administration Record (MAR) for March 2026 revealed the order for BuSpar was entered on 03/05/26. The resident received his first dose on 03/05/26 between 6:30 P.M. and 10:30 P.M. The second dose was administered on 03/06/26 between 6:30 A.M. and 10:30 A.M.Interview with Resident #4's responsible party (RP) on 03/17/26 at 3:30 P.M. revealed the facility started the resident on BuSpar 10 mg orally twice a day for an unknown reason as well as Trazodone 25 mg orally every evening. The RP stated Resident #4 has had adverse reactions to psychotropic medications in the past and did not want him on anything that crosses the blood brain barrier. She did not know the facility had started him on the medication until she went into visit and the nurse told her about it. The RP requested the medication be discontinued.Interview with the Assistant Director of Nursing (ADON) #603 on 03/18/26 at 4:30 P.M. revealed ADON #603 was given an order for BuSpar as MD #950 had completed his admission psychiatric evaluation. ADON #603 said she gave the order to ADON #524, who was on the phone with the responsible party (RP) for Resident #4 and she informed her of the new order. The following day the RP for Resident #4 came to the facility with her two children and met with ADON #603 in her office. She spoke with the RP for about an hour regarding the BuSpar order. The RP informed ADON #603 she did not want Resident #4 to take the BuSpar due to the potential side effects of the medication. ADON #603 said the resident received two doses before it was discontinued.Interview with ADON #524 on 03/19/26 at 11:35 A.M. revealed she did not notify Resident #4's family over the phone regarding the addition of BuSpar and Trazodone to the resident's medications. ADON #524 said all of her communication with the RP was in person, not over the phone. She spoke with the RP daily. ADON #524 said she received the order for BuSpar and discussed it with the RP the next day she visited. The RP said she did not want Resident #4 to be on the BuSpar and requested it not be given. Nothing was discussed regarding the order or rationale for Trazodone. ADON #524 notified the nurse practitioner when she next saw her regarding the BuSpar. The nurse practitioner discontinued the medication as requested. ADON #524 said she did not believe Resident #4 received any doses of the medication.Review of the facility's Change in the Resident's Condition or<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Status policy, last revised 05/01/25, revealed the nurse is to immediately notify the resident, consult with the resident's attending physician, on call physician, nurse practitioner, physician assistant or clinical nurse specialist, and notify the resident's authorized representative when there is a change in the mental, physical, or psychosocial status. This information must be documented in the resident's medical record. This deficiency represents noncompliance investigated under Complaint Number 2807084. |