

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Altercare of Nobles Pond, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 7006 Fulton Drive, NW 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure call lights were in working order. This affected one resident (#36) of one resident reviewed for call light placement.</p> <p>Findings Include:</p> <p>Review of Resident #36's medical record revealed the resident was admitted on [DATE] with diagnoses including pancytopenia, diabetes mellitus, and atherosclerotic heart disease.</p> <p>Review of Resident #36's admission Minimum Data Set 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.</p> <p>Review of a plan of care dated 04/21/25 revealed Resident #36 was at risk for falls. Interventions included to encourage Resident #36 to use call light for transfer/ambulation assistance.</p> <p>Observation and interview on 06/10/25 at 12:57 P.M. revealed Resident #36 needed assistance. Resident #36 stated that he had been using the call light, and it was not working. He stated that he wanted to be positioned for when lunch arrived. An attempt to activate the call light at time of observation/interview revealed the call light did not activate the electronic message board.</p> <p>Observation and interview on 06/10/25 at 1:02 P.M. with the Administrator revealed that the call light cord was pulled out of the wall and that is why it did not activate.</p> <p>Review of the policy dated 05/01/25 titled, Call Light-Answering, revealed call lights would be responded to timely to meet the resident's needs.</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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure Resident #21's left palm protector was implemented as ordered to prevent skin breakdown and prevent deformity. This affected one (Resident #21) of one resident reviewed for position and mobility.</p> <p>Findings Include:</p> <p>Review of Resident #21's medical record revealed the resident was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, muscle weakness and vascular dementia.</p> <p>Review of Resident #21's physician orders revealed an order dated 01/23/25 for a left palm protector to be placed on in the morning and removed at bedtime and to check skin integrity twice daily.</p> <p>Review of Resident #21's Quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.</p> <p>Review of Resident #21's care plans revealed an intervention dated 04/15/25 for a palm protector to the left hand.</p> <p>Review of Review of Resident #21's medication administration records and treatment administration records from 06/01/25 to 06/11/25 revealed documentation the palm protector was applied as ordered.</p> <p>Observation on 06/09/25 at 9:54 A.M. revealed Resident #21 had a contracted left hand with no palm protector in place. Interview with Resident #21 at the time of the observation confirmed the resident was supposed to wear a left hand splint during the day.</p> <p>Interview on 06/09/25 at 1:03 P.M. with Certified Nursing Assistant (CNA) #849 confirmed Resident #21's left hand palm protector was not in place as ordered by the physician. CNA #849 placed the palm protector to the left hand at this time.</p> <p>Observation on 06/11/25 at 6:15 A.M. revealed Resident #21's palm protector was on the resident's left hand and the resident was in bed sleeping.</p> <p>Interview on 06/11/25 at 6:31 A.M. with CNA #824 revealed she had helped provide care to Resident #21 around 5:00 A.M. and the palm protector was in place at that time.</p> <p>Interview on 06/11/25 at 6:33 A.M. with CNA #830 revealed she worked 10:30 P.M. to 6:30 A.M. and Resident #21's was wearing the left hand palm protector when she came in the facility. CNA #830 indicated she was not aware the palm protector was to be removed at bedtime.</p> <p>Interview on 06/12/25 at 1:11 P.M. with Regional Registered Nurse #927 revealed the facility did not have a policy regarding use of palm protectors.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on record review, observation, interview, and review of facility policy, the facility failed to provide enteral feeding as ordered for Resident #127. This affected one (#127) of one resident who received enteral feedings. The facility census was 69.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #127 revealed an admission date of 05/24/25 with diagnoses including dysphagia oropharyngeal phase, aphasia, and gastrostomy status.</p> <p>Review of the admission Minimum Data Set assessment, dated 05/31/25, revealed Resident #127 was cognitively intact, dependent on staff for activities of daily living, and received 51 percent or more of calories and 501 milliliter (ml) or more of fluids from tube feeding daily.</p> <p>Review of the physician's orders for June 2025 for Resident #127 identified an order dated 05/27/25 for continuous enteral feeding formula Isosource 1.5 at 55 ml per hour. There were no physician's orders for enteral feeding formula substitutions.</p> <p>Review of the medication administration record for 06/08/25 revealed continuous enteral feeding formula Isosource 1.5 at 55 ml per hour was signed as administered on 06/08/25 at 10:42 P.M.</p> <p>On 06/09/25 at 11:55 A.M., an observation of Resident #127 revealed the resident was sitting in bed with the head of bed elevated and Vital 1.5 enteral formula at 55 ml per hour infusing.</p> <p>On 06/09/25 at 12:40 P.M., an observation and interview with Registered Nurse (RN) #926 confirmed Vital 1.5 enteral formula was hooked up and running through Resident #127's feeding tube. RN #926 verified Resident #127 was ordered Isosource 1.5 enteral formula.</p> <p>On 06/09/25 at 1:02 P.M., an observation of the supply room revealed there were several cases of Isosource 1.5 formula available for use, which was verified by Regional RN #915 at the time of observation.</p> <p>On 06/09/25 at 1:17 P.M., an interview with Registered Dietitian (RD) #921 revealed nobody had called her regarding substituting Vital 1.5 in place of Isosource 1.5 for Resident #127. RD #921 said there should have been physician input regarding the enteral formula substitution.</p> <p>On 06/10/25 at 1:39 P.M., an interview with Medical Records Coordinator #881 revealed the current supply of enteral formula was ordered on 05/28/25 and delivered by the end of the month (May 2025). There were no other orders placed for enteral feeding formulas since then. Medical Records Coordinator #881 stated the Isosource 1.5 enteral formula was available for use and she was unsure why the Vital 1.5 enteral formula was administered instead for Resident #127.</p> <p>Review of the facility's policy titled Enteral Feeding - Continuous Pump, dated 05/01/25, revealed the facility would provide enteral nutrition and hydration in accordance with professional standards of practice, including administering the prescribed enteral feeding to residents.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure Resident #34's carbohydrates were monitored during meals, assisted with adding the carbohydrate count to the insulin pump, the resident's care plans were updated to reflect accurate interventions for caring for the resident's insulin pump, the resident's physician orders accurately reflected the amount of as needed insulin to be administered to the resident and the staff were knowledgeable in operating the resident's insulin pump. This resulted in significant insulin medication errors affecting one (Resident #34) of two residents reviewed for insulin administration. The facility census was 69.</p> <p>Findings Include:</p> <p>Review of Resident #34's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified nondisplaced fracture of the surgical neck of the right humerus, type one diabetes mellitus and spastic quadriplegic cerebral palsy.</p> <p>Review of Resident #34's admission Minimum Data Set 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Further review revealed Resident #34 was dependent upon staff for performance of all activities of daily living including eating, toileting, bathing, and hygiene.</p> <p>Review of Resident #34's care plans revealed an intervention dated 04/29/25 to approach insulin pump as per the physician's orders. There were no intervention regarding assisting Resident #34 with the carbohydrate count necessary to calculate insulin bolus via the insulin pump.</p> <p>Review of Resident #34's physician orders revealed an order dated 04/17/25 for a low concentrated sweets diet, regular texture with regular thin liquid consistency; an order dated 04/26/25 to assist the resident with entering carbohydrate counts into the resident's insulin pump to deliver a bolus of insulin after each meal, referring to carbohydrate sheets at the bedside bulletin board with meals due at 8:00 A.M., 12:00 P.M. and 5:00 P.M.; an order dated 05/01/25 for U-100 insulin fast acting insulin, 100 units/milliliter (ml), up to 90 units per day subcutaneous via an insulin pump due from 6:30 A.M. to 10:30 A.M.; and an order dated 05/21/25 to check the resident's blood sugars before meals and at bedtime and notify the physician if the blood sugar was less than 60 or greater than 400.</p> <p>Review of Resident #34's progress note authored by Licensed Practical Nurse (LPN) #813 dated 04/18/25 timed 1:31 P.M. revealed the resident's insulin pump was not working correctly and the alarm for a high blood sugar had been going off. The insulin pump showed a fasting blood sugar of over 400 with a fingerstick confirming a fasting blood sugar of 552. Ten units of Humalog insulin was administered subcutaneously.</p> <p>Review of Resident #34's progress note dated 04/19/25 timed 1:16 A.M. authored by LPN #923 indicated at approximately 12:40 A.M., the resident's insulin pump displayed a reading above 400. A finger stick was performed, and the blood sugar was 493. A note on the report sheet indicated the insulin pump was not functioning and that the son was bringing a replacement part. A review of the resident's chart showed a similar incident documented on 04/18/25 at approximately 1:30 P.M. The physician was called and awaiting on a physician to return the call.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #34's progress note dated 04/25/25 timed 9:00 P.M. authored by Registered Nurse (RN) #801 revealed the resident's insulin pump had been beeping on and off for the floor staff. The floor staff were unsure how to operate the insulin pump or what orders to use for caring for the insulin pump. The endocrinologist was contacted multiple times throughout the day requesting specific orders for administering bolus insulin as well as educational materials related to refilling the pump and changing the monitor.</p> <p>Review of Resident #34's progress note dated 05/14/24 at 5:22 A.M. authored by RN #924 revealed the blood sugar reading at 5:00 A.M. was 470. The resident stated he had been running high. The certified nurse practitioner (CNP) advised the resident to administer 8 units via the insulin pump and a new order to check the resident's blood sugars before meals and at bedtime.</p> <p>Review of Resident #34's medication administration records (MARS) and treatment administration records (TARS) from 05/01/25 to 05/31/25 revealed no evidence of entering a carbohydrate count into the resident's insulin pump to deliver a bolus of insulin after each meal on 06/01/25 at 8:00 A.M., 05/02/25 at 8:00 A.M., 05/03/25 at 8:00 A.M., 05/04/25 at 8:00 A.M., 05/04/25 at 12:00 P.M., 05/06/25 at 8:00 A.M., 05/07/25 at 8:00 A.M., 05/08/25 at 12:00 P.M., 05/09/25 at 8:00 A.M., 05/09/25 at 12:00 P.M., 05/10/25 at 8:00 A.M., 05/11/25 at 8:00 A.M., 05/11/25 at 12:00 P.M., 05/11/25 at 5:00 P.M., 05/13/25 at 12:00 P.M., 05/13/25 at 5:00 P.M., 05/14/25 at 8:00 A.M., 05/14/25 at 12:00 P.M., 05/17/25 at 8:00 A.M., 05/17/25 at 12:00 P.M., 05/19/25 at 8:00 A.M., 05/20/25 at 5:00 P.M., 05/21/25 at 8:00 A.M., 05/22/25 at 8:00 A.M., 05/27/25 at 8:00 A.M., 05/22/25 at 12:00 P.M., and 05/30/25 at 8:00 A.M.</p> <p>Review of Resident #34's MARS and TARS from 06/01/25 to 06/11/25 revealed no evidence the staff assisted the resident with carbohydrate count into the resident's insulin pump to deliver a bolus of insulin after each meal on 06/02/25 at 8:00 A.M., 06/02/25 at 12:00 P.M., 06/03/25 at 8:00 A.M., 06/06/25 at 8:00 A.M., 06/06/25 at 12:00 P.M., 06/09/25 at 8:00 A.M., 06/09/25 at 12:00 P.M., 06/09/25 at 5:00 P.M.</p> <p>Review of Resident #34's MARS and TARS dated 05/14/25 revealed to administer a one-time dose of 80 units of insulin for a blood sugar reading of 470. The MARS and TARS did not reveal evidence the nurse administered the insulin.</p> <p>An observation on 06/09/25 at 12:00 P.M. of Resident #34 while in his room revealed Resident #34 was alert, appropriately groomed and able to converse without limitations. An interview on 06/09/25 at 12:01 P.M. with Resident #34 indicated the resident had been waiting since 8:30 A.M. for the nurse on shift to tell the resident how many carbohydrate the resident had for breakfast for the insulin bolus and a blood sugar of 207. Resident #34 requested assistance to remove his glucose monitor from his pocket so that he could check his blood sugar. He shared that he was unable to do so because he had limited ability to move his right arm due to right shoulder and upper arm fracture. He further shared that he did not have the ability to grasp things with his left hand due to cerebral palsy.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 06/09/25 at 12:47 P.M. with RN #926 confirmed that she did not assist Resident #34 with a carbohydrate count for his insulin bolus due at 8:00 A.M. and 12:00 P.M. RN #926 shared that they did not know that they were supposed to provide Resident #34 with a carbohydrate count and thought that the insulin pump delivered insulin automatically. Further, RN #926 shared they were not familiar with insulin pumps in general. RN #926 verified the physician's order to assist Resident #34 to calculate carbohydrate counts at each meal to be programmed into the insulin pump for an insulin bolus was on Resident's #34 medication administration record. RN #926 stated that she would notify the doctor.</p> <p>An interview On 06/10/25 at 7:54 A.M. with Resident #34 revealed that he had a list of carbohydrate counts for common foods at his bedside. Resident #34 shared that he did not add up the total carbohydrates based on the provided information and that nurses were supposed to do this for him. Resident #34 stated that occasionally the nurses did not assist him with the carbohydrate counts and that he was unable to independently calculate carbohydrate counts and program them into his insulin pump. Further, he shared that while at home he ate the same foods most of the time and he knew the carbohydrate counts without calculation, also he had food package instructions to help him figure out serving sizes, and full use of his dominant side prior to falling at home. Resident #34 stated that he had no way of knowing what the serving sizes were at the facility. Resident #34 was alert and laying in bed during this interview. Resident #34 denied ever experiencing discomfort related to elevated or low glucose levels.</p> <p>An interview on 06/10/25 at 7:46 A.M. with Regional RN #915 revealed that the nurse was to supply Resident #34 with the carbohydrate count for each meal, using the chart at his bedside. Resident #34 then injected the correct dose of insulin via his insulin pump.</p> <p>An interview on 06/10/25 at 4:54 P.M. with Regional RN #915 verified that carbohydrate counts were not documented for multiple days/shifts and that she could not verify that the insulin bolus were given.</p> <p>An interview on 06/11/25 at 9:20 A.M. with LPN #813 revealed that Resident #34 usually walked the staff through the process with his insulin pump and that he knew everything about his insulin pump. LPN #813 indicated that she routinely went online with her phone and looked up carbohydrate counts based on serving sizes Resident #34 gave her. LPN #813 was not sure how Resident #34 determined serving sizes. LPN #813 shared that they were not provided with education on the insulin pump for Resident #34 and they were not sure what brand or type of insulin pump he used.</p> <p>An interview on 06/11/25 at 9:34 A.M. with Regional RN #915 verified that the medical record for Resident #34 contained no orders to monitor glucose prior to 05/14/25.</p> <p>An interview on 06/11/25 at 9:39 A.M. with Assistant Director of Nursing (ADON) #802 revealed that the glucose levels for Resident #34 were tracked on his insulin pump. ADON #802 verified that the expectation for residents with continuous glucose monitoring was to obtain blood glucose levels and to record them at regular intervals. The facility was unable to provide glucose monitoring data prior to 05/14/25 for Resident #34. ADON #802 furthered shared that no education was provided to the staff for Resident #34's insulin pump and that it was not a routine practice to provide staff education for residents admitted with devices unfamiliar to staff.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 06/11/25 at 2:30 P.M. with RN #924 revealed that they made a transcription error when receiving orders for an elevated glucose level for Resident #34. RN #924 shared that they did not administer 80 units of insulin to Resident #34 and they did not know much about Resident #34 or his insulin pump other than his blood sugar was high and they called the Nurse Practitioner (NP) on call. The NP ordered 8 units of insulin and that was what RN #924 gave Resident #34.</p> <p>An interview on 06/11/25 at 2:45 P.M. with the Director of Nursing (DON) verified that Resident #34's care plan did not reflect current orders specifically carbohydrate counting.</p> <p>An interview on 06/11/25 at 2:58 P.M. with Regional RN #927 revealed that when care plans were done, they were general and not specific. If they were too specific to the orders, then they would have to update them every time an order was changed.</p> <p>An interview on 06/11/25 at 3:30 PM with the DON revealed that Resident #34 had not been assessed for self-administration of medication and it was not expected that the residents would self-administer medications. The DON verified that the facility did not have any documentation of staff education for the use, care, and maintenance of Resident #34 insulin pump or for carbohydrate counting.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Deficiency Text Not Available</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. Review of Resident #31's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, adult failure to thrive and unspecified dementia with hospice services. Review of Resident #31's physician orders revealed an order dated 05/16/25 for a regular diet, thin liquid consistency with a four ounce fortified nutritional treat daily at lunch. Review of Resident #31's Significant Change in Status MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.</p> <p>Review of Resident #31's care plans revealed an intervention dated 06/10/25 to provide the diet per the physician's order.</p> <p>Review of Resident #31's lunch meal ticket dated 06/10/25 revealed a regular diet regular texture with a thin liquid consistency with milk, coffee, one fortified ice cream, Salisbury steak, mashed potatoes with brown gravy, peas and apple crisp.</p> <p>Observation on 06/10/25 at 11:34 A.M. revealed Resident #31 was sitting on side of bed waiting on the lunch meal.</p> <p>Observation on 06/10/25 at 12:10 P.M. revealed Resident #31's meal tray was delivered to the resident. A four ounce fortified nutritional treat was not on the meal tray as ordered by the physician.</p> <p>Interview on 06/10/25 at 12:20 P.M. with CNA #810 confirmed Resident #31's lunch meal tray did not include the fortified ice cream as indicated on the resident's meal ticket.</p> <p>5. Review of Resident #32's medical record revealed the resident was admitted on [DATE] with diagnoses including systemic lupus, weakness and need for assistance with personal care. Review of Resident #32's physician orders revealed an order dated 04/18/25 for a regular diet, regular thin liquid consistency with no bananas or seafood per an allergy and provide four ounces of fortified nutritional treat daily at lunch. Review of Resident #32's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and lost weight of more than five percent in the last month or 10 percent in the last six months.</p> <p>Review of Resident #32's lunch meal ticket revealed a regular diet, regular thin liquids consistency with allergies to bananas and shellfish. The meal ticket indicated to add one fortified ice cream, Salisbury steak, mashed potatoes with brown gravy, peas, apple crisp and milk/beverage.</p> <p>Interview on 06/10/25 at 11:51 A.M. with Resident #32 revealed the resident was aware of a recent weight loss and was happy with the weight loss.</p> <p>Observation on 06/10/25 at 12:20 P.M. of Resident #32's meal tray revealed the tray did not have four ounces of fortified nutritional treat on the tray as ordered by the physician.</p> <p>Interview on 06/10/25 at 12:25 P.M. with Regional Licensed Social Worker #922 confirmed Resident #32's lunch tray did not include a fortified nutritional treat.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review, the facility failed to provide residents with their preferences during meals. This affected five (#28, #30, #31, #32, and #40) of six residents reviewed for food and drink. The facility census was 69.</p> <p>Findings Include:</p> <p>1. Review of Resident #28 medical record revealed the resident was admitted on [DATE] with diagnoses including anorexia, adult failure to thrive and anxiety disorder. Review of Resident #28's care plans revealed an intervention dated 11/25/24 to provide the diet per the physician's order and honor preferences. Review of Resident #28's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #28 exhibited moderate cognitive impairment. Review of Resident #28's physician orders for June 2025 revealed an order for a regular diet, thin liquid consistency.</p> <p>Observation on 06/09/25 at 1:36 P.M. revealed Resident #28's lunch ticket indicated the resident chose apple juice but received cranberry juice. This was verified by Certified Nursing Assistant (CNA) #832 at time of observation.</p> <p>Interview and observation on 06/11/25 at 8:50 A.M. revealed Resident #28 taking a drink and then indicating the beverage tasted horrible and she was supposed to get apple juice. Activities Coordinator #881 verified that the drink was not the color of apple juice, and the meal ticket indicated Resident #28 was to receive apple juice.</p> <p>Interview on 06/11/25 at 8:53 A.M. with Dietary Aide (DA) #896 verified Resident #28 did not receive apple juice, she received lemonade.</p> <p>2. Review of Resident #30's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic respiratory failure with hypoxia, sepsis, muscle wasting and atrophy. Review of Resident #30's care plans revealed an intervention dated 12/28/20 to provide the diet per the physician's order and honor preferences. Review of Resident #30's physician orders for June 2025 revealed an order for a regular diet, thin liquid consistency.</p> <p>Observation of Resident #30's breakfast meal and meal ticket on 06/09/25 at 9:47 A.M. revealed Resident #30 selected cheddar egg bake, coffee cake, hash brown patty, and cranberry juice. Resident #30 did not receive the hash brown patty and received orange juice instead of cranberry juice on her breakfast tray. CNA #832 verified the ticket and stated that the kitchen ran out of hash browns.</p> <p>3. Review of Resident #40's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, fracture of right femur and hypo-osmolality and hyponatremia. Review of Resident #40's care plans revealed an intervention dated 08/23/22 to provide the diet per the physician's order and honor preferences. Review of Resident #40's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #40 exhibited moderate cognitive impairment. Review of Resident #40's physician orders for June 2025 revealed an order for a regular diet, thin liquid consistency.</p> <p>Observation of Resident #40's meal ticket on 06/09/25 at 9:35 A.M. revealed Resident #40 selected cheddar egg bake and a hash brown patty for breakfast but was not served the hash brown patty on his breakfast tray. CNA #832 verified the meal ticket and stated the kitchen ran out of hash browns.</p>		

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

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interview, and policy and procedure review the facility failed to ensure food was stored in a manner to protect from contamination/spoilage, the oven was maintained in a clean/sanitary manner, and food was prepared/served in accordance with standards for food service safety. This had the potential to affect 68 out of 69 residents receiving food from the kitchen. Resident #127 was identified as not receiving anything by mouth and received no food from the kitchen. The facility census was 69.</p> <p>Findings Include:</p> <p>Observation during tour of the kitchen on 06/09/25 at 8:10 A.M. with the Dietary Manager revealed in the dry goods storage room there was an open bag of cake mix and an open bag of instant mashed potatoes with no label or date as to when opened. Inside the walk-in freezer there were frozen french toast sticks in a zip lock bag and an opened bag of biscuits with no labels or dates. In the preparation area, the oven had food residue and food splatter on it.</p> <p>Observation on 06/10/25 from 11:30 to 12:53 P.M. during lunch meal service tray line revealed that at 11:59 A.M., Dietary Aide #889 took a deli sandwich out of a sandwich bag with her bare hands and placed it on a plate for a resident.</p> <p>Review of the facility policy dated 08/12/20 titled, Dating Foods, revealed open food items in the cooler/refrigerator, freezer, storeroom was to be labeled with the opened date, expiration date, and food item name.</p> <p>Review of the facility policy dated 02/2014 titled, Glove Usage revealed no barehand food contact was allowed. Gloves must be worn when handling food whether it was ready to eat or going to be cooked as part of the process.</p> <p>Review of the facility policy dated January 2020 with a revision date March 2022 titled, Operation and Cleaning Procedures, revealed that all areas of the kitchen were to cleaned daily to insure proper sanitation in the operation.</p>

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NAME OF PROVIDER OR SUPPLIER Altercare of Nobles Pond, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately document the details of a fall and fall investigation. This affected one resident (#10) out of two residents reviewed for falls. The facility census was 69.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #10 revealed an admission date of 03/17/25 and readmission date of 05/13/25 with diagnoses including bilateral osteoarthritis of the knee, atrial fibrillation, difficulty in walking, type two diabetes mellitus, chronic obstructive pulmonary disease, bipolar disorder, hypertension, acute and chronic respiratory failure with hypoxia, and weakness.</p> <p>Review of the admission assessment dated [DATE] revealed Resident #10 was at low risk for falls with a score of 4.0 (the assessment indicated high risk was a score of 10.0 or higher).</p> <p>Review of the fall investigation report dated 05/20/25 timed 6:00 A.M. indicated Resident #10 had a fall with injury. The question asking Was the patient injured? was answered Other: -states none. The question asking Further assessment/findings related to injury: was answered Resident self-reported fall but said she did not hurt self and had no issues. The assessment indicated the nurse practitioner (NP) was notified on 05/21/25 at 1:00 P.M. and the resident representative was notified on 05/21/25 at 2:15 P.M. Resident #10 reported a pain level of zero. The assessment indicated the resident reported pain the following day, an x-ray was ordered and the results were negative. The investigation report was closed on 05/22/25 at 3:05 P.M.</p> <p>Review of the fall investigation report dated 05/22/25 timed 3:10 P.M., with a note indicating it was for the self reported fall on 05/20/25, indicated Resident #10 had a fall with injury. The question asking Was the patient injured? was answered Other: - none reported. The question asking Further assessment/findings related to injury: was answered Resident reported fall but unsure of when it happened. States no injury. The assessment indicated the nurse practitioner and resident representative were notified on 05/20/25 at 6:00 A. M. (which was inconsistent with the dates/times of notification listed on the other assessment for this same fall). Resident #10 reported a pain level of zero. The assessment indicated an x-ray was ordered the day after the fall. The investigation report was closed on 06/10/25 at 2:36 P.M.</p> <p>Review of the progress note dated 05/22/25 timed 12:05 P.M., written by NP #914, indicated Resident #10 reported a recent fall in the restroom with head involvement and the resident was unsure of what day it occurred, reporting it was possibly on 05/17/25 (which was inconsistent with the date reported on the two fall investigation reports). There was a small abrasion on the back of the head (which was inconsistent with the findings reported in the two fall investigation reports), Resident #10 denied any headache, Resident #10 complained of right thigh pain, and x-rays were negative.</p> <p>(continued on next page)</p>		

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

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan, dated 06/04/25, revealed Resident #10 was at risk for falls or injury related to bowel incontinence, bladder incontinence, anti-depressant, anti-hypertensive, anti-convulsant, anti-psychotic, diabetic oral hypoglycemic, diuretic, and impaired gait stability. Interventions included occupational therapy as per plan, physical therapy as per plan, educate resident about limitations and safety concerns, encourage resident to use call light for assistance, encourage resident to wear glasses, evaluate resident safety with devices, identify non-compliance with safety issues and report to the physician as needed, observe resident for safety needs, redirect for safety as needed, pharmacy and physician to review medications with resident visits, report any possible medication side effects, and observe for mental and physical side effects with device use.</p> <p>On 06/10/25 at 9:15 A.M., an interview with Resident #10 stated she had one fall since arriving to the facility. Resident #10 said she fell while self-transferring, hit her head, and hurt her arm.</p> <p>On 06/10/25 at 3:06 P.M., an interview with Regional Registered Nurse (RN) #915 verified there were two incident reports for the same incident for Resident #10, both with an incident type of fall with injury, and on both incident reports, the question asking what injury the resident had was answered as none.</p> <p>On 06/10/25 at 4:07 P.M., an interview with the Director of Nursing (DON) confirmed Resident #10's fall was classified as a fall with injury even though the incident reports indicated there was no injury and no pain. The DON said there were two incident reports because the first one was accidentally closed out before it was completed and confirmed the information in the two assessments did not match.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure call lights were in working order. This affected one resident (#36) of one resident reviewed for call light placement. Findings Include: Review of Resident #36's medical record revealed the resident was admitted on [DATE] with diagnoses including pancytopenia, diabetes mellitus, and atherosclerotic heart disease. Review of Resident #36's admission Minimum Data Set 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of a plan of care dated 04/21/25 revealed Resident #36 was at risk for falls. Interventions included to encourage Resident #36 to use call light for transfer/ambulation assistance. Observation and interview on 06/10/25 at 12:57 P.M. revealed Resident #36 needed assistance. Resident #36 stated that he had been using the call light, and it was not working. He stated that he wanted to be positioned for when lunch arrived. An attempt to activate the call light at time of observation/interview revealed the call light did not activate the electronic message board. Observation and interview on 06/10/25 at 1:02 P.M. with the Administrator revealed that the call light cord was pulled out of the wall and that is why it did not activate. Review of the policy dated 05/01/25 titled, Call Light-Answering, revealed call lights would be responded to timely to meet the resident's needs.</p>