STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365109	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altenheim	18627 Shurmer Road Strongsville, OH 44136

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, witness statement review, policy review and interview, the facility failed to ensure Resident #120's right great toe ulcer/abrasion was timely identified, assessed, monitored and treated and failed to complete wound treatments as ordered for Resident #90. Actual harm occurred when Resident #120, who was assessed as severely cognitively impaired, totally dependent on staff for most activities of daily living (ADL's) and had a history of infection to the right great toe, was found to have a right great toe skin impairment beginning in 05/05/25, however there was no nurse assessment or monitoring or physician-ordered treatment of the right great toe skin impairment from 05/05/25 to 07/05/25. Subsequently, on 07/05/25, Resident #120 developed a fever and an oozing, reddened, edematous, and malodorous right great toe, was sent to the emergency room and was diagnosed with osteomyelitis and sepsis due to the wound resulting in a five-day hospital stay requiring intravenous antibiotics. This affected two (Residents #120 and #90) of three residents reviewed for wounds. The census was 120.Findings include:1.Review of the medical record for Resident #120 revealed an admission date of 12/17/22 with diagnoses which included functional quadriplegia, dementia, Alzheimer's disease with early onset, metabolic encephalopathy, cellulitis of right toe, and acute osteomyelitis of right ankle and foot. Review of the skin integrity care plan dated 06/07/23 revealed Resident #120 had alteration in skin integrity due to actual sacral/coccyx pressure ulcer wound, history of pressure ulcers, advanced Alzheimer's dementia with severe cognitive deficits, peripheral venous stasis, history of chronic edema, advanced age, fragile skin, cardiac disease, presence of suprapubic catheter, history of penile erosion, and incontinence, and right great toe blister. Interventions included: inspect skin during routine care as needed, skin assessments per protocol, and monitor of signs and symptoms of infection: fever, redness, odor, purulent drainage, change in drainage consistency and type, increase in size of wound, pain, edema, and notify physician of changes. Review of the podiatrist progress note dated 02/21/25 revealed Resident #120 had a partial thickness ulcer noted to the dorsal right hallux (great toe) with resolving cellulitis noted to digit. There was mild peri-wound erythema. Hyperkeratotic tissue noted to the margins of the wound. Mild drainage noted. Wound measured: approximately 1 centimeter. Plan: debridement ulcer right foot with application antibiotic ointment, resident to finish oral antibiotics and reassess in three weeks. Review of the Skin Audit Report for State tested Nurse Aides (STNA's) dated 04/14/25 revealed Resident #120 had skin integrity issues red area scabbed on toes. and all 10 toes were circled. A nurse signed the Skin Audit Report. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Minimum Data Set (MDS) 3.0 annual assessment dated [DATE] revealed Resident #120 was severely cognitively impaired, had fluctuating inattention, used a wheelchair for mobility, and was totally dependent on staff for bathing, upper and lower body dressing, putting and taking off footwear, personal hygiene, rolling left and right, toileting, and transferring from bed to chair. Review of the Skin Audit Report for STNA's for Resident #120 dated 05/05/25 revealed Resident #120 had a skin integrity issue on the R toe with a dressing that was not new. A nurse signed the Skin Audit Report. Review of the physician orders from May 2025 revealed Resident #120 was ordered weekly skin checks – complete PointClickCare (PCC) [electronic medical record] Skin and Wound - Total Body assessment every night shift every Wednesday for skin integrity; the order began on 11/20/24. In addition, Resident #120 was ordered Complete Foot Assessment weekly on skin check day every night shift every Thursday for skin integrity; the order began on 11/20/24. Review of the May 2025 Treatment Administration Record (TAR) revealed Resident #120 had a Total Body Skin assessment on 05/07/25, 05/14/25, 05/21/25, and 05/28/25. Resident #120 had a Complete Foot Assessment on 05/07/25, 05/21/25 and 05/28/25; there was no evidence Resident #120 had a Complete Foot Assessment on 05/14/25. Review of the wound care physician progress note dated 05/07/25 revealed there was no evidence Resident #120's right great toe was assessed. Review of the Skin Audit Report for STNA's for Resident #120 dated 05/12/25 revealed there was a circle around the right great toe describing a bandage on the toe. A nurse signed the Skin Audit Report. Review of the Skin Audit Report for STNA's dated 05/19/25 revealed Resident #120 had a skin integrity issue and there was a circle around the right great toe describing a bandage on the toe. A nurse signed the Skin Audit Report. Review of the Foot/Podiatric Assessment II dated 05/21/25 revealed Resident #120 had thickened toenails. There was no evidence of skin impairment on the right great toe. Review of the wound care physician progress note dated 05/21/25 revealed there was no evidence Resident #120's right great toe was assessed. Review of the PCC Skin and Wound – Total Body Skin assessment dated [DATE] revealed Resident #120 did not have any new wounds. Review of the Skin Audit Report for STNA's dated 05/26/25 revealed Resident #120 had a skin integrity issue and there was a circle around the right great toe describing a bandage on the toe. A medication aide signed the Skin Audit Report. Review of the wound care physician progress note dated 05/28/25 revealed there was no evidence Resident #120's right great toe was assessed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Skin Audit Report for STNA's for Resident #120 dated 05/30/25 revealed there was circle around the right great toe describing a bandage to the toe. A nurse signed the Skin Audit Report. Review of the June 2025 Treatment Administration Record (TAR) revealed Resident #120 had a Total Body Skin assessment on 06/04/25, 06/11/25, 06/18/25 and 06/25/25 and a Complete Foot Assessment on 06/04/25, 06/11/25, 06/18/25 and 06/25/25. Review of the Skin Audit Report for STNA's dated 06/02/25 revealed Resident #120 had a skin integrity issue on the right big toe that was not new. There was a circle around the right great toe. A nurse signed the Skin Audit Report. Review of the PCC Skin and Wound – Total Body Skin assessment dated [DATE] revealed Resident #120 did not have any new wounds. Review of the Foot/Podiatric Assessment II dated 06/04/25 revealed Resident #120 had thickened toenails. There was no evidence of skin impairment on the right great toe. Review of the wound care physician progress note dated 06/04/25 revealed there was no evidence Resident #120's right great toe was assessed. Review of the Skin Audit Report for STNA's dated 06/06/25 revealed Resident #120 had a skin integrity issue on the right big toe that was not new. There was a circle around the right great toe. Review of the Skin Audit Report for STNA's for Resident #120 dated 06/09/25 revealed Resident #120 had skin integrity issues with patches on indicted areas above not new. There was a circle around the right great toe. A nurse signed the Skin Audit Report. Review of the wound care physician progress note dated 06/09/25 revealed there was no evidence Resident #120's right great toe was assessed. Review of the PCC Skin and Wound – Total Body Skin assessment dated [DATE] revealed Resident #120 did not have any new wounds. Review of the Foot/Podiatric Assessment II dated 06/12/25 revealed there was no evidence Resident #120 had skin impairment on the right great toe. Review of the Skin Audit Report for STNA's for Resident #120 dated 06/13/25 revealed there was a circle around the right great toe. A nurse signed the Skin Audit Report. Review of the wound care physician progress note dated 06/16/25 revealed there was no evidence Resident #120's right great toe was assessed. Review of the PCC Skin and Wound – Total Body Skin assessment dated [DATE] revealed there was no evidence Resident #120 had a new wound. Review of the Skin Audit Report for STNA's dated 06/20/25 revealed Resident #120 had skin integrity issues and there was a circle around Resident #120's right toes describing a bandage on the toes. A nurse signed the Skin Audit Report. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Skin Audit Report for STNA's for Resident #120 dated 06/23/25 revealed Resident #120 had no new [skin impairments]. A medication aide signed the Skin Audit Report. Review of the wound care physician progress note dated 06/23/25 revealed there was no evidence Resident #120's right great toe was assessed. Review of the Skin Audit Report for STNA's dated 06/30/25 revealed Resident #120 had skin integrity issues and there was a circle around the right great toe describing a bandage on the toe. A nurse signed the Skin Audit Report. Review of the wound care physician progress note dated 06/30/25 revealed there was no evidence Resident #120's right great toe was assessed. Review of the July 2025 Treatment Administration Record (TAR) revealed there was no evidence Resident #120 had a Total Body Skin assessment on 07/02/25, as ordered however Resident #120 had a Complete Foot Assessment on 07/02/25. Review of Resident #120's medical record revealed no evidence of the Complete Foot Assessment completed on 07/02/25. Review of the Skin Audit Report for STNA's for Resident #120 dated 07/04/25 revealed there was a circle around the right great toe describing a bandage on the toe. A nurse did not sign/acknowledge the Skin Audit Report. Review of the Change of Condition assessment dated [DATE] timed 3:02 P.M. authored by Licensed Practical Nurse (LPN) #520 revealed Resident #120 had abnormal vital signs and a skin issue: febrile with a 102.4 degree Fahrenheit (F) fever, right foot was warm, redness, edema and foul odor. Right foot had 2+ pitting edema. Resident noted to have a foam dressing to his right toe with no proper treatment documented in PCC. When this nurse took foam dressing off of right great toe/foot, foot appeared red, had 2+ pitting edema, warm to touch and had a foul odor. No drainage noted besides scant amount of dried blood to foam dressing. This nurse cleaned foot and left it open to air. Vital collected as resident also seemed drowsier than this baseline, but able to respond. Febrile with temperature noted to be 100.7 degrees F, all other vitals stable and no signs of sepsis noted. Tylenol administered as 1:38 P.M. and Physician #751 notified. This nurse checked temperature and vital signs again 30 minutes after Tylenol administration and fever increased to 102.4 degrees F, other vitals stable. Physician #751 gave new order to send to hospital, if Resident #120's wife wanted 911 then that was okay. Resident #120's wife present and decided on 911. Resident sent out 911 to hospital and left facility at 2:40 P.M. Resident #120's wife appreciative and left with emergency medical services. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital physician admission/history and physical progress note dated 07/05/25 timed 5:46 P. M. revealed chief complaint: unable to obtain, per Resident #120's wife, she noted a spot on his toe and brought it to the attention of nursing staff at nursing home. History of present illness: 85-year-male old presenting to the emergency department due to right foot infection, has history of ESBL/VRE infections. Resident's wife reported that he has had a spot on his right great toe which had been managed with local wound care however the dressing had not been changed in several days. She asked for nursing home staff to open it today and then noticed it was foul-smelling. This prompted her evaluation in the emergency room. Presented with fever and found to have leukocytosis (an increase of white blood cells in the blood, especially during an infection) of 19,000 (normal between 4,000 to 11,000), hypokalemia 3.3 (normal 3.5 to 5.2), anemia of hemoglobin of 12 (normal 13.5 to 17.6) and 39 (normal <36%). C-Reactive Protein (CRP) elevated at 102.2 (normal <10.0). X-Ray of right foot showed lucency of the 2nd through 5th metatarsals concerning for osteomyelitis – question of subcutaneous gas of the hindfoot concern for infection. Twelve-lead EKG showed sinus rhythm with occasional premature ventricular contraction (PVCs) 67 beats per minute. Physical exam: there was an ulcer of the right great toe with redness erythema and edema, decreased pulsation over the dorsalis pedis (DP) pulse of the right lower extremity. Assessment/plan: osteomyelitis right foot 2nd to 5th metatarsals heads with suspicious for gas producing infection/necrotizing infection of the right lower extremity, acute metabolic encephalopathy, hypokalemia, leukocytosis, anemia. Admit, Vanc/Zosyn/Clinda (antibiotics), follow cultures, MRI right foot, arterial studies/ABI to eval PAD, vascular/podiatry/infectious disease consults, replace potassium, and Lovenox. Review of the change of condition note dated 07/05/25 timed 6:20 P.M. authored by LPN #520 revealed this nurse phoned Resident #120's wife for update on resident and wife stated resident was staying overnight in hospital and that he had osteomyelitis to his foot and was started on two antibiotics in hospital. Review of the hospital physician progress note dated 07/07/25 timed 1:34 P.M. revealed history of present illness: sepsis from foot wound and mental status change. Review of the undated witness statement authored by LPN #520 revealed, on Saturday 07/05/25, [Resident #120's wife name] brought to this nurse's attention that she had received a bill in the mail for podiatry. She asked if [Resident #120] was on the podiatrist list. This nurse educated wife that resident was taken off the podiatrist list per her request in the past. Wife asked about a foam dressing that was on resident's right great toe and why it was there. I stated that I was not aware of a foam dressing being placed on his right great toe and there was no treatment in place. Wife also concerned due to resident being drowsy but arousable. This nurse assess resident, noted to have 100.7 fever with all other vitals within normal limits, noted to be more drowsy that his baseline. Foot assessed and a foam dressing was on right great toe, removed by this nurse. No initials, date or name was on dressing and looked fairly new. Foot appeared red, had 2+ pitting edema, warm to touch, and foul odor. Foot also appeared dry and scabbed area noted to inner great toe. This nurse cleansed toe and left open to air while reporting to [Physician #751]. This nurse has not seen to recently to recall when foot initially appeared this way. No previous verbal reports by staff were given to this nurse. Resident sent to [hospital] via 911 at 2:40 P.M. with wife present. Review of the witness statement authored by Certified Nurse Aide (CNA) #677 dated 07/08/25 revealed, I have not seen [Resident #120's] toe uncovered. He has had a bandage on it. I marked the shower sheet when I gave him a shower. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the witness statement authored by CNA #663 dated 07/08/25 revealed, over the past week, I have observed [Resident #120] toe covered in a pink padded bandage. I have not seen it uncovered. Review of the witness statement authored by CNA #665 dated 06/08/25 revealed, I [CNA #665] did not notice his R toe due to it being covered. Review of the nurses note dated 07/10/25 revealed Resident #120 returned from hospital at 6:10 P.M., vitals take by this nurse. 151/64 blood pressure, 18 respirations rate, 98.5 tympanic temperature, 105 pulse and 93% room air.Resident had a skin tear on right hand, bruising to the left side of abdomen, black scab on left [incorrect] big toe, blister on left leg and peripherally inserted central catheter (PICC) line in left arm. Review of the wound physician note dated 07/14/25 revealed Resident #120 had a right great toe abrasion measuring 0.8 centimeters by 0.6 centimeters with a scab with the plan to continue intravenous antibiotics for right great toe osteomyelitis. Observation on 10/20/25 at 11:05 A.M. revealed Resident #120 was sitting in a wheeled shower chair being pushed from the shower room into his room by two nurse aides. Interview, during the observation, with Resident #120 with attempted however unsuccessful. Interview on 10/20/25 at 11:35 A.M. with LPN/Unit Manager #523 revealed night shift nurses were supposed to complete resident's head-to-toe skin checks once a week. LPN #523 revealed she was unaware Resident #120 had a wound on the right great toe. LPN #523 verified Resident #120 did not have treatment order for the right great toe and verified she had no knowledge there was a dressing in place to the right great toe. Observation on 10/20/25 at 9:47 A.M. at Unit Three nursing station revealed there was a undated schedule hanging on the wall at the nursing station. The sign read, Unit 3: head to toe and foot assessment schedule. Tuesday: [Resident #120's room number]. These assessments must be completed under the assessment tab prior to you signing them in the TAR [treatment administration record]. There are two assessments to be completed per room. Observation on 10/20/25 at 1:20 P.M. revealed Resident #120 was sitting in a wheelchair in his room with his wife standing by his side. Interview, during the observation, with Resident #120 was attempted however unsuccessful. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/20/25 at 1:20 P.M. with Resident #120's wife revealed she visited with Resident #120 for eight hours a day, every day so when she came in to visit on 07/05/25, the wife noticed the resident wasn't feeling good; he was sleeping a lot and kind of out of it. Resident #120's wife asked LPN #520 to check him and take his vital signs. LPN #520 found the resident to have a slight temperature and gave him Tylenol, however his temperature then increased. LPN #520 stated that the resident had an infection however she didn't know where. That was when Resident #120's wife asked, when is the bandage coming off his toe? Because it's been on there awhile. Resident #120's wife described the bandage as a big bandage with tape and covered the whole toe and the bandage wasn't dated or initialed. LPN #520 checked the computer and stated there wasn't anything in the computer about the toe. LPN #520 then removed the bandage from the right great toe which the toe was oozing pus (unknown color), swollen and malodorous. Resident #120's wife described it as awful and so bad. Resident #120 was sent to the hospital and diagnosed with osteomyelitis and was on all these antibiotics. The hospital told Resident #120's family he may lose part of his foot or whole foot. Resident #120's wife discussed the right great toe wound with the Director of Nursing (DON) and Administrator who reported no one knew about the wound and they didn't find out what happened. Physician #751 reported to Resident #120's wife that [the wound] wasn't in the computer. Interview on 10/20/25 at 1:35 P.M. with Physician #751 (Resident #120's primary care physician) revealed Physician #751 was unaware Resident #120 had a wound on the right great toe prior to 07/05/25. Physician #751 was sent a picture via text message of the resident's toe on 07/05/25 which showed the great toe was edematous, clearly infected and Physician #751 knew the resident was going to need IV antibiotics, a podiatrist consultation and imaging; it looked bad. Physician #751 stated there was a Band-Aid or a dressing of some sort covering his toe however the physician did not observe the dressing, only the foot. Physician #751 verified she was aware there was no documentation in the medical record for the right great toe. Interview on 10/20/25 with the DON (with the Administrator present) verified the following: Resident #120's shower sheets of a right great toe skin impairment began on 05/05/25, Resident #120's last Foot/Podiatric assessment under the assessment tab in the electronic medical record (EMR) was on 06/12/25, Resident #120's last Total Body Skin assessment under the assessment tab in the EMR was on 06/19/25, there was no corresponding Total Body Skin assessment under the assessment tab in the EMR from the weekly skin check on 06/19/25, there was no evidence a Total Body Skin assessment/weekly skin check was completed on 07/02/25, there was no physician ordered treatment for Resident #120's right great toe prior to 07/05/25, and Resident #120's right great toe was not being assessed and monitored by nursing. Interview on 10/21/25 at 9:15 A.M. with Resident #120's son revealed he had requested Resident #120's medical records from the facility. The son reviewed the facility's progress notes, Medication Administration Record (MAR's) and TAR's and noticed Resident #120 had a wound on his toe since May 2025 and there wasn't a treatment order for the toe. When Resident #120 was sent to the hospital during early July 2025, the hospital physician told Resident #120's family the resident might lose his toe or half his foot. Resident #120's son stated he was concerned that his father was going to die from an infection at the facility rather than old age. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Observation on 10/21/25 at 9:23 A.M. revealed Resident #120's great toe treatment had was in place and dated 10/20/25. The right great toe noted to bend straight down at the knuckle (metatarsophalangeal joint). At the joint, there was a circular area that was being treated. Interview, during the observation, with Wound Nurse (WN) #563 revealed his toes had fractures from when he was younger due to playing football. He had great toenails removed prior to being admitted to the facility due to recurrent ingrown toenails. WN #563 stated she spoke to the resident's wife about getting him set up with a podiatrist regularly and wife stated she would. WN #563 stated during the time of April 2025 through 07/05/25, WN #563 had not noticed the right great toe having a bandage or a skin area. WN #563 did weekly rounds with the wound physician/wound nurse practitioner. WN #563 stated staff were supposed to update her with new skin areas. WN #563 was not updated until the day he went to the hospital. Interview on 10/21/25 at 2:15 P.M. with LPN #520 revealed on 07/05/25, Resident #120's wife notified LPN #520 that Resident #120 had a foam dressing on his right great toe and inquired when the last time the dressing was changed. The nurse was unaware of the foam dressing and when LPN #520 removed the foam dressing, the resident's right great toe was inflamed, red and had foul odor coming from the dressing. LPN #520 stated the dressing was not labeled, dated or initialed. LPN #520 report the findings to the physician, and the resident was sent to the hospital. LPN #520 revealed she hadn't seen a bandage on the right toe before 07/05/25. Interview on 10/21/25 at 3:30 P.M. with WN #563 (with the Administrator present) verified Resident #120 had a Foot/Podiatric assessment completed on 07/02/25 according to the July 2025 TAR however there was not a corresponding Foot/Podiatric assessment completed on 07/02/25 under the assessments tab in the EMR. Review of the facility undated Recognition and Assessment policy revealed direct care staff such as the assigned nursing assistant would be responsible to examine the resident's skin integrity during each care contact, i.e. during dressing, bathing, toileting, incontinence care, repositioning, etc. The nursing assistant would be responsible and expected to immediately report to their charge nurse any identified problems such as any redness, callus formation, abrasion, ecchymosis areas or other break in skin integrity. On resident shower days, the STNA would complete a Resident Shower Sheet and forward to the charge nurse for review. The charge nurse or treatment nurse complete a weekly head to toe assessment, as appropriate, on the resident and documents in the resident medical record. The charge nurse would be responsible for informing the resident's provider when any area of concern were identified so that appropriate measures could be taken to alter the plan of care and/or implement a treatment protocol if necessary. Existing wound were assessed by the wound nurse and wound provider on a weekly basis as appropriate for new areas, stagnant or declining wounds for effectiveness of current interventions and/or treatment. Weekly assessment findings would be recorded and entered in PCC. Review of the facility's undated Treatment and Interventions policy revealed unless otherwise specified by the provider, the facility's treatment protocols for each skin integrity type would be in accordance with current standards of practice. Generally, dressing would not be removed until the ordered dressing was due to be changed unless there were signs of dressing contamination or observations that indicate a clinical problem. Integrity of wound dressings would be monitored with each interaction and be replaced in they were not intact/placed as ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Review of the medical record for Resident #90 revealed an admission date of 07/08/24 with diagnoses including dementia, chronic kidney disease and a pressure ulcer to the left heel and right heels. Review of the physician's orders for Resident #90 revealed an order to cleanse the left heel wound with normal saline, pat dry, swab with Betadine, cover with an abdominal (ABD) pad and wrap with kerlix every day and as needed dated 07/17/25. Review of the care plan dated 07/19/25 for Resident #90 revealed she was at risk for impaired skin integrity and had an unstageable pressure ulcer (type of pressure ulcer when the stage is not clear due to the base of the wound being obscured by dead tissue in the wound) to her left heel. Interventions included to perform treatments as ordered by the physician. Review of the treatment administration record (TAR) for Resident #90 for September 2025 and October 2025 revealed nursing staff had not completed the treatment to her left heel wound on 09/06/25, 09/10/25, 09/12/25, 09/15/25, 09/26/25, 09/29/25, 10/04/25, 10/05/25, 10/10/25, 10/13/25, 10/18/25 and 10/19/25. Interview on 10/21/25 at 1:32 P.M. with the Director of Nursing verified Resident #90's treatments to her left heel were not performed on the dates listed above. Review of the facility policy titled, Treatment and Interventions, undated, revealed unless specified by the provider, the facility's treatment protocols for each skin injury type will be in accordance with current standards of practice. This deficiency represents non-compliance investigated under Complaint Number 2601761.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365109	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altenheim	18627 Shurmer Road Strongsville, OH 44136

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and interview, the facility failed to ensure staff performed urinary catheter care and monitored urine output as ordered by the physician. This affected two (Residents #79 and #120) of three residents reviewed for urinary catheters. The facility census was 120.Findings include:1. Review of the medical record for Resident #79 revealed an admission date of 09/30/25 with diagnoses including urinary retention, obstructive and reflux uropathy (blockage in the urinary tract that prevents urine from flowing normally). Review of the physician's orders for Resident #79 revealed an order for foley catheter care each shift dated 09/30/25. Review of the baseline care plan dated 09/30/25 for Resident #79 revealed she had a foley catheter and staff would provide catheter care as ordered. Review of the treatment administration record (TAR) for October 2025 revealed staff had not completed foley catheter care including monitoring urinary output on night shift on 10/03/25, 10/09/25, 10/10/25 and on dayshift on 10/10/25 and 10/17/25. Interview on 10/21/25 at 1:32 P.M. with the Director of Nursing verified Resident #79's foley catheter care was not performed on the dates listed above. Review of the facility policy titled, Urinary Catheter Care, dated April 2013, revealed care should be provided every shift and as needed. 2. Review of the medical record for Resident #120 revealed an admission date of 12/17/22 with diagnoses including dementia and obstructive and reflux uropathy (blockage in the urinary tract that prevents urine from flowing normally). Review of the care plan dated 06/07/23 for Resident #120 revealed he had alteration in elimination related to having a catheter. Interventions included for staff to perform suprapubic catheter care as ordered and monitor output as needed. Review of the physician's orders for Resident #120 revealed an order for suprapubic catheter (a catheter inserted directly into the bladder) care each shift dated 02/05/25 that was discontinued on 07/07/25. A new order on 07/22/25 was noted to monitor foley output every shift. Review of the treatment administration record (TAR) for May 2025, June 2025 and July 2025 revealed staff had not completed suprapubic catheter care for Resident #120 on dayshift on 05/01/25, 06/09/25 and on nightshift on 05/02/25, 05/08/25, 05/09/25, 05/14/25, 05/22/25, 05/27/25, 05/28/25, 06/02/25, 06/11/25, 06/24/25, 06/27/25, 06/30/25 and 07/02/25. Review of the TAR for July 2025, August 2025 and September 2025 also revealed Resident #120 did not have his foley output monitored on nightshift on 07/22/25, 07/23/25, 07/31/25, 08/03/25, 08/06/25, 08/07/25, 08/19/25, 08/20/25, 08/26/25, 08/28/25, 08/29/25, 09/05/25, 09/08/25, 09/16/25, 09/17/25, 09/19/25, 09/22/25, 09/25/25, 09/26/25 and on dayshift on 07/25/25 and 08/16/25. Interview on 10/21/25 at 1:32 P.M. with the Director of Nursing verified Resident #120's suprapubic catheter care and output was not monitored on the dates listed above. Review of the facility policy titled, Urinary Catheter Care, dated April 2013, revealed care should be provided every shift and as needed. This deficiency represents non-compliance investigated under Complaint Number 2601761.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365109	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altenheim	18627 Shurmer Road Strongsville, OH 44136

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review, observation and interview, the facility failed to implement proper infection control policies and procedures including surveillance of facility infections and contact isolation precautions (wearing gown and gloves) when in Resident #60's room. This affected one (Resident #60) of three residents reviewed for isolation precautions but had the potential to affect all residents related to not performing proper infection control surveillance. The facility census was 120.Findings include:1. Review of the monthly infection control surveillance logs from September 2024 through October 2025 revealed the facility did not have surveillance for the months of August 2025, September 2025 and October 2025. Interview on 10/21/25 at 12:00 P.M. with the Assistant Director of Nursing (ADON) #750 verified she had not started working on August 2025, September 2025 and October 2025 infection control surveillance logs. She stated she tracked infections but was unable to answer how she monitored for trending infections when the logs were not being kept up to date. Additional interview on 10/21/25 at 12:50 P.M. revealed ADON #750 ran a report at the end of each month for orders of new antibiotics and she utilized the information for her infection control surveillance log. Review of the facility policy titled, Antibiotic Stewardship Program, dated 05/15/24, revealed the infection prevention and control nurse would track and monitor facility infections and the amount of antibiotics used in the facility.2. Review of the medical record for Resident #60 revealed an admission date of 11/14/21 with diagnoses including chronic kidney disease, heart failure, diabetes mellitus, dementia and Extended Spectrum Beta Lactamase (ESBL) resistance (bacteria that is resistant to common antibiotics). Review of the physician's orders for Resident #60 revealed she had a peripherally inserted central catheter (PICC) dated 10/10/25. Resident #60 had an order dated 10/10/25 for contact precautions for ESBL. Observation on 10/20/25 at 10:45 A.M. revealed a sign on Resident #60's door alerting staff and visitors that she was on contact isolation. The instructions stated everyone must clean hands when entering room and wash hands with soap and water when leaving the room and put on a gown and gloves at the door. There was personal protective equipment (PPE) noted sitting by Resident #60's door including gloves and gowns. Licensed Practical Nurse (LPN) #536 performed hand hygiene and put on gloves. She then went into Resident #60's room and performed care on her PICC line. LPN #536 did not have a gown on during the observation. LPN #536 verified she should have donned a gown prior to going into Resident #60's room. Review of the facility policy titled, Infection Control, dated January 2012, revealed contact precautions were needed for multi-drug resistant organisms. Contact isolation included utilizing gown and gloves.This deficiency represents non-compliance investigated under Complaint Number 2601761.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365109	A. Building B. Wing	10/21/2025

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Altenheim	18627 Shurmer Road Strongsville, OH 44136

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to implement their antibiotic stewardship program to ensure appropriate use of antibiotics. This affected one (Resident #120) of three residents reviewed for antibiotic usage. The facility census was 120.Findings include:Review of the medical record for Resident #120 revealed an admission date of 12/17/22 with diagnoses including dementia, pressure ulcers, history of urinary tract infections and cellulitis of the right great toe, Review of the facility infection control surveillance for September 2024 through July 2025 revealed Resident #120 had been on antibiotics on 10/15/24 (for urinary tract infection), 11/01/25 (for urinary tract infection), 11/20/25 (for clostridium difficile, or infection of the colon that causes diarrhea), 02/18/25 (for cellulitis of the toe), 03/06/25 (for infection to the right toe), 03/31/25 (for increased white blood count), 04/03/25 (for continued increased white blood count), 06/09/25 (for conjunctivitis, or infection of the eye), and 07/10/25 (for osteomyelitis, or infection of the bone).Review of Resident #120's assessments revealed he did not have antibiotic time out assessments (standardized tool and criteria that assesses the symptoms of the resident and usage of the antibiotic) performed on 11/20/24, 02/18/25, 03/31/25-04/03/25, and 06/19/25.Interview on 10/21/25 12:50 P.M. with the Assistant Director of Nursing (ADON) #750 verified staff had not performed the antibiotic time out assessments for Resident #120 on 11/20/24, 02/18/25, 03/31/25-04/03/25, and 06/19/25. She stated the facility utilized the antibiotic time out assessments to ensure residents' symptoms warranted antibiotic usage and was part of their antibiotic stewardship program.Review of the facility policy titled, Antibiotic Stewardship Program, dated 05/15/24, revealed the infection prevention and control nurse would track all antibiotic starts as infection surveillance and monitor adherence to criteria during the evaluation and management of treated infections.This deficiency represents non-compliance investigated under Complaint Number 2601761.