

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Altercare of Bucyrus Center Fo		STREET ADDRESS, CITY, STATE, ZIP CODE 1929 Whetstone Street Bucyrus, OH 44820	
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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. Based on observation, staff interview and facility policy review, the facility failed to provide a safe smoking area for all residents. This affected all residents in the facility. The census was 66. Observation on 07/30/25 at 10:55 A.M. revealed smoking shack did not have designed smoking times posted to enable nonsmokers to avoid the area during the posted times. There were also numerous cigarette butts on the ground outside the smoke shack, on the concrete and in the landscaping mulch, and one half smoked cigarette beside the ashtray receptacle in the smoke shack. Interview with Director of Nursing (DON) on 07/30/25 at 11:00 A.M. confirmed no smoking times were posted and numerous cigarette butts were on the ground. Review of the undated policy titled Smoking-Resident policy revealed the designated smoking area will be posted with proper signage designated the area as a smoking area and include the designated smoking times to enable nonsmokers to avoid the area during the posted times.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of facility water temperature logs, and review of the facility policy, the facility failed to maintain safe water temperatures. This had the potential to affect all residents residing on the 300-hall (Resident #6, #8, #9, #19, #21, #22, #26, #30, #34, #35, #50, #55, #56, #58, #60, #62, #65, #67, and #71), all residents residing on the 400-hall (#5, #12, #13, #14, #20, #23, #27, #32, #68, and #69) and residents residing in room [ROOM NUMBER]. The facility census was 66. Review of the facility's hot water temperature logs for 07/02/25 through 07/24/25, revealed on 07/09/25 the hot water temperature in room [ROOM NUMBER] was 127 degrees Fahrenheit, the hot water temperature in room [ROOM NUMBER] was 128 degrees Fahrenheit, and the hot water temperature in room [ROOM NUMBER] was 124 degrees Fahrenheit. On 07/24/25, the hot water temperature in room [ROOM NUMBER] was 123 degrees Fahrenheit, the hot water temperature in room [ROOM NUMBER] was 122 degrees Fahrenheit, the hot water temperature in room [ROOM NUMBER] was 124 degrees Fahrenheit, and the hot water temperature in room [ROOM NUMBER] was 123 degrees Fahrenheit. On 07/28/25, the hot water temperature in room [ROOM NUMBER] was 128 degrees Fahrenheit, the hot water temperature in room [ROOM NUMBER] was 125 degrees Fahrenheit, the hot water temperature in room [ROOM NUMBER] was 130 degrees Fahrenheit, and the hot water temperature in room [ROOM NUMBER] was 128 degrees Fahrenheit. Observations on 07/28/25 from 11:47 A.M. through 12:38 P.M. of the facility's secured memory care unit (400-hall) revealed hot water temperatures were taken for all bathrooms located in all resident rooms. Hot water temperatures in resident bathrooms ranged from 130 degrees Fahrenheit to 132 degrees Fahrenheit. Observations on 07/28/25 from 12:40 P.M. to 12:50 P.M. of rooms located near each end of the 300-hall revealed hot water temperatures in resident bathrooms were 130 degrees Fahrenheit. An interview on 07/28/25 at 1:17 P.M. with Maintenance Director #530 verified hot water temperatures on the 300-hall and 400-hall had been running high for several weeks and were supposed to be below 120 degrees Fahrenheit. Maintenance Director #530 reported the facility had some plumbing work completed on 07/02/25 and the hot water temperatures in resident rooms located on the aforementioned halls began running high following that work. Maintenance Director #530 reported they had contacted the plumbing company who completed the work, but the company had not been able to come back and did not always show up when they said they were going to. Maintenance Director #530 reported they had not contacted a second plumbing company regarding the hot water temperatures that had been running too high and had not implemented any measures to protect residents while water temperatures remained high. Maintenance Director #530 was asked several times and reported there was no way for the facility to physically turn the temperatures down in the facility. On 07/28/25 from 1:27 P.M. through 1:35 P.M., Maintenance Director #530 used the facility's digital thermometer to test the hot water temperature in the bathrooms of room [ROOM NUMBER], #312, and #405, and obtained a reading of 132 degrees Fahrenheit for each room. On 07/28/25 from 1:31 P.M. through 1:50 P.M., Maintenance Director #530 checked the hot water temperature in the bathroom of room [ROOM NUMBER] and #501 and obtained a reading of 130 degrees Fahrenheit for each room. Interviews on 07/28/25 with Maintenance Director #530 at the time of each observation verified the hot water temperatures in each resident bathroom. A follow-up interview on 07/28/25 at 3:03 P.M. revealed Maintenance Director #530 spoke with a regional maintenance worker and was informed and instructed to turn the hot water temperature down on hot water tanks located in the facility. Maintenance Director #530 reported the hot water tanks were previously set to 140 degrees Fahrenheit and were just turned down to 125 degrees Fahrenheit. Observation on 07/28/25 at 3:03 P.M. of two hot water tanks located in the facility revealed each hot water tank had a separate gage with the ability to be adjusted. Both hot water tanks were set to approximately 125 degrees (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fahrenheit. Review of the facility policy titled Water Temperature Policy, not dated, revealed staff were to check with their regional support staff on whether temperature locations applied to the specific type of facility, and to ensure patient room temperatures were between 105 and 120 degrees in Ohio.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility staff interview, and facility policy review, the facility failed to follow physician's order for oxygen administration. This affected two residents (#34 and #28) out of nine residents identified to received oxygen at the facility. The facility census was 66. Review of medical record for Resident #34 revealed admission date of 04/03/25. The resident was admitted with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), bipolar disorder and neuromuscular dysfunction of bladder. The Minimum Data Set (MDS) dated [DATE] revealed Resident #34 had a Brief Interview Mental Status (BIMS) score of 13 indicating no impaired cognition. Resident #34 was dependent for meals, dependent with toileting hygiene, bed mobility and transfers. Review of the physician orders dated 05/30/25 revealed continuous oxygen at 1 liter per minute via nasal cannula. Indicated for COPD exacerbation. Keep Resident #34's oxygen saturation level above 90 percent (%) and check twice a day. Observation on 07/29/25 at 11:56 A.M. revealed Resident #34 was wearing nasal cannula with oxygen running at a rate of 0.5 liters of oxygen per minute. Interview with Licensed Practical Nurse (LPN) #512 on 07/29/25 at 12:44 P.M. confirmed Resident #34's oxygen was set at 0.5 liter of oxygen per minute and the physician's order was for one liter of oxygen per minute. 2. Review of medical record for Resident #28 revealed an admission date of 12/04/21. The resident was admitted with diagnoses of post polio, Type II Diabetes, rheumatoid arthritis, non-pressure chronic ulcer of unspecified part of right lower leg, wedge compression fracture of first lumbar vertebra, and sequela. The Minimum Data Set (MDS) dated [DATE] revealed Resident #28 had a Brief Interview Mental Status (BIMS) score of 15 indicating no impaired cognition. Resident #28 was set up for meals, dependent with toileting hygiene, bathing, and transfers. Review of the physician orders revealed an order dated 04/16/25 for oxygen at 2 liter per nasal cannula for resident comfort. Check twice a day. Observation on 07/29/25 at 3:37 P.M. revealed Resident #28 was wearing nasal cannula with oxygen running at a rate of one liters of oxygen per minute. Interview with Director of Nursing on 07/29/25 on 12:44 P.M. confirmed Resident #28's oxygen was set at one liter of oxygen per minute and the physician's order was for two liter of oxygen per minute. Review of policy titled Oxygen Administration, dated 05/01/25, revealed: verify there is physician's orders for service.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, facility staff interview, and facility policy review, the facility failed to ensure infection control standards were implemented and maintained during medication administration. This affected one (Resident #62) of four residents observed for medication administration. The facility census was 66. Observation of medication pass on 07/29/25 at 8:59 A.M. revealed Licensed Practical Nurse (LPN) #512 was observed entering Resident #21 room, placed right hand on resident's shoulder, then returned to the medication cart to pull medication for Resident #62. LPN #512 did not sanitize hands between tasks. Interview with (LPN) #512 at 9:10 A.M. confirmed no hand sanitization was complete in between medication pass between Resident #21 and Resident #62. Review of policy titled Medication Administration-General Guidelines, dated May 2020, revealed hand sanitation is to be completed when returning to medication cart and regular intervals during medication pass such as after each room.		