STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365750	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Somerset Inc.	411 South Columbus Street Somerset, OH 43783

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 28923 Based on observation, resident interview, and staff interview, the facility failed to ensure residents had the right to a safe, clean, and sanitary environment. This affected 42 of 67 residents (25 residents were identified to not use the facility's two shower rooms (Residents #3, #4, #6, #17, #21, #22, #36, #37, #38, #39, #42, #44, #47, #48, #50, #52, #53, #54, #55, #59, #63, #64, #65, and #66). The facility's census was 67. Findings include: On 10/28/24 at 10:25 A.M., an observation of the facility's main shower room on Unit 1 revealed the commode in the shower room was missing a toilet seat. There was a black colored substance on the vinyl floor, near the left side of the shower stall where the vinyl flooring met the tiled shower stall's floor. The black substance was not a stain and transferred to a paper towel when using it to wipe over the black substance. There was also dirt and grime build-up in the grout lines of the tiled shower stall floor and in the lower half of the tiled walls that enclosed the shower stall. The dirt and grime on the tiled floor covered about half of the surface area of the floor. The cleaner areas had gray colored grout lines, while the dirtier areas had dark gray to black grout lines. The vinyl flooring in front of the shower stall was peeling back mid-way and to the right end of the shower stall. The floor's underlayment was exposed where the vinyl flooring was peeling back. A metal transition strip was noted to go across the shower stall separating the tiled floor of the shower stall with the vinyl flooring that covered the resident of the shower room's floor. On 10/28/24 at 10:31 A.M., an observation of the facility's main shower room on Unit 2 revealed the grout lines between the tiled floor in the shower stall also had dirt and grime build-up. The grout lines were dark gray to black in color instead of the gray color it should have been. Dirt and grime build-up was also noted in the grout lines between some of the wall tiles that surrounded the shower stall. There was torn vinyl flooring noted to the left of the shower stall. The torn areas in the vinyl floor had a sealant that had been applied over the cracks in the vinyl, but the sealant was coming loose. The shower room also had a strong mildew odor that was present and noticeable when entering the shower room. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/28/24 at 3:15 P.M., a follow up observation was made of the environmental concerns noted earlier in the facility's two shower rooms. The Director of Nursing (DON) accompanied the surveyor and verified the findings. Unit 1's shower room was noted to have standing water in the area where the vinyl flooring was peeling back in from of the shower stall. The water was puddled right over top of the area where the vinyl flooring was peeling back away from the transition strip in front of the shower stall where the vinyl flooring and the tiled floor met. Other findings previously mentioned were still present in the Unit 1 shower room. The shower stall in Unit 2's shower room was noted to have a brown substance that looked like feces on the floor. No residents or other staff were in there at the time the observation was made. The DON stated the shower stall should be cleaned/ disinfected between each resident use. She acknowledged Unit 2's shower room had a strong mildew odor in it that was noticeable when entering the shower room. The other concerns noted in Unit 2's shower room remained. The DON reported she would have to have the shower rooms clean and would see about getting the toilet seat to the commode in Unit 1 fixed. On 10/28/24 at 3:30 P.M., an interview with Resident #14 revealed she had concerns about mold in the facility's shower rooms and it was like that on both sides. She claimed that was mold that was on the wall and on the floor. She mentioned the area of the vinyl flooring that was coming up and exposing the underlayment beneath it. She stated that could not be good for the water to be getting under the vinyl flooring. She alleged it had been like that for the past year or year and a half. They (facility) have said that they were going to fix it, but had to wait on something. She was not sure what they were waiting on and did not feel it should have taken that long to be fixed. She also confirmed the toilet seat on the commode in Unit 1's shower room had been off for about a month or a month and a half. This deficiency represents non-compliance investigated under Complaint Number OH00158499.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 28923 Based on review of a facility self-reporting incident (SRI), it's related investigation, staff interview, and policy review, the facility failed to ensure resident's personal money was not misappropriated by facility staff. This affected one resident (#36) of one residents reviewed for misappropriation and one of two SRI's reviewed. Findings include: Review of SRI with tracking #251595 dated 09/06/24 revealed an allegation of misappropriation was alleged involving Resident #36 and facility staff member. The initial source of the allegation was a facility staff member. Resident #36 was indicated to have been able to provide meaningful information when interviewed. The narrative summary of the incident revealed the date and time of the occurrence was on 09/20/24 at 11:30 A.M. and in the resident's room. Resident #36 reported he had lent a staff member (Housekeeper #77) $20.00 and it had not been paid back yet. Staff notified the administrator immediately of that allegation. An interview was conducted with Resident #36 who reported Housekeeper #77 had asked to borrow $10.00 from him approximately two months ago. He stated he did not have $10.00, but he had a $20.00, so he lent her $20.00. He denied reporting it to anyone before then. He did not have any concerns and he wanted to help Housekeeper #77, as they were friendly and got along well. Resident #36 reported no further concerns. An interview with Housekeeper #77 was conducted and she admitted she borrowed the $20.00 and had not paid it back yet. She denied she had asked any other residents to borrow money or accepted money from any other residents. She was placed on administrative leave pending the investigation. The Administrator interviewed other staff and residents with no relative concerns reported. The facility unsubstantiated the allegation indicating the evidence indicated misappropriation did not occur. As a result of the investigation, the facility could not conclude that misappropriation, or the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent, occurred. Resident #36 was reimbursed in the amount of $20.00. The facility indicated they followed the abuse reporting policy. Review of the facility's related investigation for SRI #251595 revealed the facility's administrator obtained a statement from Resident #36 on 09/06/24. She documented the interview on an Event Statement form that was identified as a Quality Assessment and Assurance (QAA) form. She documented Resident #36 stated approximately two months ago, Housekeeper #77 had asked him to borrow $10.00. He stated he only had a $20.00, so he lent her $20.00. He indicated they got along well and he was happy to help her. He had not reported it to anyone until then. Resident #36 indicated he was not concerned, he was just wondering when he could get his $20.00 back. It was explained to the resident that the facility would reimburse him and provided education to the resident to report any concern immediately. He indicated he did not report it because he was not concerned but voiced understanding that staff were not permitted to ask residents for money or to borrow money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the facility's related investigation revealed the facility's administrator documented her interview she conducted with Housekeeper #77 on 09/06/24. The facility's Director of Nursing (DON) was indicated to be present at the time of the interview, as well as the facility's housekeeping supervisor. When asked about the allegation of her borrowing money from a resident and not paying it back, Housekeeper #77 became tearful and stated yes I did that and I know better, I haven't paid him back yet but I can. She stated she felt she and the resident had a good relationship and she asked to borrow $10.00 dollars, but the resident only had a $20.00, so he lent her the $20.00 approximately two months ago. She denied she had asked to borrow money or had accepted money from any other residents. She then stated I promise I have never done that before or since then, I know I shouldn't have and I know this isn't allowed. It was communicated to the housekeeper that she would be placed on administrative leave pending the investigation, and the housekeeper voiced understanding. Review of a written statement obtained from Housekeeper #77 on 09/11/24 confirmed she asked Resident #36 to borrow $10.00 and he gave her $20.00. A month went by and she did not pay it back. Resident #36 asked another employee if she (Housekeeper #77) still worked there and that she had borrowed money from him and had not paid him back yet. Housekeeper #77 stated another employee reported it to her supervisor. Review of Housekeeper #77's employee personnel file revealed she received disciplinary action on 09/11/24. The disciplinary action indicated it was her first offense. The date of the violation was on 09/06/24 and the employer statement indicated the employee violated Section 11 of the Employee Handbook under prohibited conduct specifically #16, and #36. Number 16 was accepting money, gifts, gratuities etc. from the residents, the resident's families, or visitors. Number 36 pertained to unprofessional behavior or conduct. On 10/28/24 at 4:51 P.M., an interview with the DON revealed they had the state investigator from the abuse, neglect, and misappropriation department in a couple weeks ago and they reviewed the allegation of misappropriation and the facility's investigation. They also talked with Housekeeper #77 while there. She stated there was nothing that came out of that from what she knew. The facility's administrator was out of the facility during the complaint investigation. The DON was asked why the facility unsubstantiated the allegation, when the employee confirmed she asked to borrow money from Resident #36. She stated the resident consented to loan her the money. She acknowledged staff members were not permitted to ask the resident's for monetary assistance, after staff had made the resident believe that staff were in a financial crisis. Staff were in a position that may be perceived as one of power over a resident. As such, staff may be able to manipulate or unduly influence decisions by the resident. Staff must not accept or ask a resident to borrow money through request for a loan or solicitation. A resident's apparent consent was not valid if it it was obtained through coercion or fear, whether it was expressed by the resident or suspected by staff. Review of the facility's policy on Abuse, Mistreatment, Neglect, Injuries of Unknown Origin, and Misappropriation of Resident Property. Misappropriation was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. An investigation of the allegation or suspicion would be conducted. After investigation, the facility should reach a conclusion analyzing all the evidence and making a determination whether the allegation or suspicion was substantiated. This deficiency represents an incidental finding of non-compliance investigated under Master Complaint Number OH00159030.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of shower schedules, resident interview, staff interview, and policy review, the facility failed to ensure residents, who were dependent on staff for personal care, received the assistance they needed for bathing/ showers. This affected three residents (#8, #14, and #20) of four residents reviewed for showers. Findings include: 1. Review of Resident #8's closed medical record revealed the resident was admitted to the facility on [DATE]. He remained in the facility until he was discharged to an inpatient rehabilitation unit on 10/24/24. His diagnoses included orthopedic aftercare, infection of a surgical site, fracture of the upper end of the right femur, difficulty walking, muscle weakness, and pressure ulcers on his bilateral heels. Review of Resident #8's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. he was not known to have displayed any behaviors nor was he known to reject care. He was dependent on staff for bathing/ showers. Review of Resident #8's active care plans revealed the resident had a care plan in place for an impaired ability to perform or participate in daily activities of daily living (ADL) care related to fracture of left upper & right upper femurs, fracture of left & right pubis, fracture of sacrum, bilateral fracture of acetabulum, bilateral fracture of ilium, laceration of spleen, bilateral contusion of kidneys, bilateral flank hematomas, abnormal posture, muscle weakness, and other symbolic dysfunctions. The care plan was initiated on 03/12/24. The goal was for the resident to participate with ADL's as much as possible and he would remain clean and dry, comfortable, and neat in appearance daily. Interventions included providing nail care and shampoo hair with showers per weekly schedule; groom hair daily and encourage resident to participate as able; provide/assist with am and pm care; encourage resident to participate with hygiene as tolerated; assist with and/or shave facial hairs every day prn or per resident preference; provide assistance with all ADL care and mobility as needed/ anticipate resident needs as able. Review of the shower schedule for Unit 2 revealed Resident #8 was scheduled to receive a shower or bath every Tuesday, Thursday, or Saturday. His shower was to be provided on day shift (7A to 3P). Review of Resident #8's shower documentation from 09/26/24 through 10/24/24 revealed there was no documented evidence of the resident being given a shower or bath on his scheduled shower days on 09/28/24, 10/05/24, 10/12/24, 10/15/24, and 10/19/24 (five of the 12 days he was scheduled). There was no evidence of the resident refusing his bath or a shower those days on the shower sheets or in the nurses' progress notes. On 10/29/24 at 10:06 A.M., email correspondence with the facility's Director of Nursing (DON) confirmed she did not have any documented evidence to support Resident #8 being given a bath or a shower on his scheduled shower days on 09/28/24, 10/05/24, 10/12/24, 10/15/24, or 10/19/24. She reported the shower sheets were where the staff documented the bath or shower when it had been given. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #14's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included polyosteoarthritis, muscle weakness, difficulty walking, unsteadiness on feet, chronic pain syndrome, morbid obesity, and pain in right shoulder. Review of Resident #14's quarterly MDS assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was not known to display any behaviors or reject care. Review of Resident #14's active care plans revealed the resident had a care plan in place for an impaired ability to perform or participate in daily ADL care related to polyosteoarthritis and weakness. The care plan was initiated on on 03/12/24. The goal was for the resident to participate with ADL's as much as possible and she would remain clean and dry, comfortable, and neat in appearance daily. The interventions included providing nail care and shampoo hair with showers per weekly schedule; groom hair daily and encourage the resident to participate as able; provide/assist with am and pm care; encourage the resident to participate with hygiene as tolerated; assist with and/or shave facial hairs every day and prn or per resident preference; observe/report any decline in ADL's, mobility or cognition; Provide assistance with all ADL care and mobility as needed; anticipate resident needs as able; and encourage resident to participate with care as tolerated. Review of the shower schedule for Unit 1 revealed Resident #14 was scheduled to receive a shower or bath every Tuesday, Thursday, or Saturday. The shower or bath was to be completed on day shift. Review of Resident #14's shower documentation on paper shower sheets for the past 30 days (09/26/24 through 10/26/24) revealed there was no documented evidence of the resident receiving a bath or a shower on 09/28/24, 10/03/24, 10/05/24, 10/12/24, or 10/17/24 (five of the 14 showers that were scheduled during that time). There was no indication that the baths or showers were offered and refused. On 10/28/24 at 3:30 P.M., an interview with Resident #14 revealed she was supposed to get showers every Tuesday, Thursday, and Saturday. She reported it was more common than not for her to only receive two showers a week, instead of the three she was scheduled for and preferred. She indicated this past week, she did not get a shower on Thursday or Saturday. She stated the shower she was supposed to get Saturday was not done until Sunday. They only had two aides on the floor those days and it made it hard for them to get the showers done. She denied she refused any showers when offered. On 10/29/24 at 10:06 A.M., email correspondence with the facility's DON confirmed she did not have any documented evidence to support Resident #14 being given a bath or a shower on her scheduled shower days on 09/28/24, 10/03/24, 10/05/24, 10/12/24, or 10/17/24. She denied the missed showers/ baths on the resident's scheduled shower day was related to staffing in any way. She indicated baths and showers were only documented on the paper shower sheets and she did not have anything else to prove they had been offered and/ or refused. 3. Review of Resident #20's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included difficulty walking, abnormalities of gait and mobility, muscle weakness, bipolar disease, Parkinson's disease, and morbid obesity. Review of Resident #20's quarterly MDS dated [DATE] revealed the resident did not have any communication issues and he was cognitively intact. No behaviors were known, but the resident was indicated to have rejected care during that seven day assessment period. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's active care plans revealed the resident had a care plan in place for an impaired ability to perform or participate in daily ADL Care related to a T5-T6 vertebrae fracture and rib fractures. The goal was for the resident to participate with ADL's as much as possible and will remain clean and dry, comfortable, and neat in appearance daily. The interventions included to observe/report any decline in ADL's, mobility or cognition; provide assistance with all ADL care and mobility as needed; anticipate resident needs as able; encourage resident to participate with care as tolerated. Review of the shower schedule for Unit 2 revealed Resident #20 was scheduled to receive a bath or a shower every Monday, Wednesday, and Friday. The bathing activity was to take place on the day shift. Review of Resident #20's documented showers revealed he was documented as having received a shower or bath on all scheduled days except 10/18/24 (1 of 14 opportunities). There was no documented evidence of the resident refusing that bath or shower when scheduled. On 10/29/24 at 10:06 A.M., email correspondence with the facility's DON confirmed she did not have any documented evidence to support Resident #20 being given a bath or a shower on his scheduled shower days on 10/18/24. She was not able to provide evidence of a bath or shower having been offered and refused for 10/18/24. This deficiency represents non-compliance investigated under Complaint Number OH00158499 and Complaint Number OH00158311.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure a resident's nutritional status was adequately monitored by recording meal percentages and fluid intake amounts that were consumed during her stay in the facility. This affected one resident (#69) of three residents reviewed for nutrition. Findings include: Review of Resident #69's closed electronic medical record (EMR) revealed she was admitted to the facility on [DATE] for a respite stay. She remained in the facility until 08/24/24, when the resident's family opted to take her home, prior to the end of her five day respite stay. Her diagnoses included Alzheimer's disease, dementia without behavioral disturbances, unspecified protein calorie malnutrition, hypertensive heart disease with heart failure, pressure ulcer to an unspecified site and at an unspecified stage, contractures of muscles of multiple sites, and a personal history of malignant neoplasm of the breast. Review of Resident #69's physician's orders revealed the resident had an order in place for her breakfast, lunch, and dinner intakes, as well as the resident's fluid intakes. The order had been in place since 08/22/24. Review of Resident #69's meal and fluid intakes revealed there had not been a single meal or a single fluid ounce of liquids that had been documented as having been consumed by the resident during her stay in the facility between 08/22/24 and 08/24/24. The report was ran by the facility's Director of Nursing (DON) and provided for review on 10/24/24 at 1:56 P.M. On 10/24/24 at 2:05 P.M., an interview with the DON confirmed the report she provided for Resident #69's meal and fluid intakes did not have any documentation on it at all. She reported the staff should have been entering the resident's meal and fluid intakes into the computer, after they occurred. She denied they had anywhere else where the resident's meal percentage consumption and her fluid amounts she drank would have been recorded. She acknowledged without the documentation, she could not show evidence of the resident receiving three meals a day or given fluids throughout the day. She further acknowledged they could not show adequate monitoring of the resident's nutritional status as it was not able to be determined how much the resident was eating or drinking to maintain her proper nutritional and hydration status. She could not explain why there was no documentation for the resident during her three day stay in the facility. This deficiency represents an incidental finding of non-compliance investigated under Master Complaint Number OH00159030.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure a resident's medical record was complete and accurate to reflect activities of daily living (ADL) care that was provided to the resident while in the facility. This affected one resident (#69) of four residents reviewed for accuracy of medical records. Findings include: Review of Resident #69's closed electronic medical record (EMR) revealed she was admitted to the facility on [DATE] for a respite stay. She remained in the facility until 08/24/24, when the resident's family opted to take her home, prior to the end of her five day respite stay. Her diagnoses included Alzheimer's disease, dementia without behavioral disturbances, unspecified protein calorie malnutrition, hypertensive heart disease with heart failure, pressure ulcer to an unspecified site and at an unspecified stage, contractures of muscles of multiple sites, and a personal history of malignant neoplasm of the breast. Review of Resident #69's care plans revealed she had care plans in place to address her being at risk for skin breakdown, having existing wounds, and receiving hospice care. The interventions included the need to assist the resident with bed mobility, observing the resident for any incontinence episodes and provide incontinence care as needed, hospice aide to provide a shower/ bath and assist with personal hygiene care 1-3 x's weekly, shower or bathe per resident schedule and tolerance, and provide oral care. Review of Resident #69's Point of Care History report from 08/22/24 to 08/24/24 revealed the facility staff did not document the provision of any ADL care to the resident on 08/22/24 and 08/23/24 (first two days of her three day stay). There was no documentation of any ADL care being provided until 08/24/24 at 5:47 A.M. when the resident was finally documented as having received ADL assistance to include bed mobility, transfers, eating, toilet use, bathing assistance, and toileting. On 10/24/24 at 2:05 P.M., an interview with the DON confirmed the facility's Point of Care History did not document any ADL care that had been provided to Resident #69 for the first two days of her three day stay. She reported the resident was assisted with those things, but they were not documented. She was not able to explain why the staff did not document ADL care when they occurred. This deficiency represents an incidental finding of non-compliance investigated under Master Complaint Number OH00159030.