

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365750	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/23/2024
NAME OF PROVIDER OR SUPPLIER  Altercare Somerset Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923</b></p> <p>Based on record review, review of the facility's 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 needed to receive showers as scheduled. This affected three (Resident #3, #9, and #30) of three residents reviewed for activities of daily living (ADL).</p> <p>Findings include:</p> <p>1. Review of Resident #3's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a dislocation of his right hip prosthesis, unsteadiness on feet, repeated falls, diabetes mellitus with diabetic neuropathy, muscle weakness, malignant neoplasm of the prostate, congestive heart failure, and hypertension.</p> <p>Review of Resident #3's admission 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 display any behaviors nor was he known to reject care during the seven days of the assessment period. He required substantial assistance with showers/baths and transfers.</p> <p>Review of Resident #3's care plan revealed he had a care plan in place for ADL functional status which required therapy services related to a decline in his prior level of function of ADL's/mobility. It was due to an impaired ability to perform ADL's and difficulty walking and the goal was for his ADL function to improve. The interventions included allowing him as much independence with ADL's as possible while still maintaining his safety, provide encouragement as needed to participate with ADL's daily and to offer praise for his efforts, provide assistance as needed with ADL's and to refer to the resident's profile for ADL assistance needed.</p> <p>Review of the Unit 2 shower schedule revealed Resident #3 was to receive a shower/bath every Tuesday, Thursday, and Saturday on the day shift.</p> <p>Review of Resident #3's shower documentation from 11/26/24 to 12/21/24 revealed the resident had no documented evidence of receiving showers/baths on his scheduled shower days on six of the 12 opportunities he was to receive one. There was no evidence he received a shower or bath on 11/30/24, 12/05/24, 12/07/24, 12/10/24, 12/19/24 or 12/21/24. He was further indicated to have only received a partial bed bath on 11/28/24, which was a scheduled shower day.</p> <p>(continued on next page)</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #9's medical record revealed he was admitted to the facility on [DATE]. He remained in the facility until he was discharged home on 12/20/24. His diagnoses included orthopedic aftercare, infection of a surgical site, fracture of the upper end of his femur, difficulty walking, muscle weakness, adult onset diabetes mellitus, depression, acute and chronic respiratory failure, and abnormalities of gait and mobility.</p> <p>Review of Resident #9's admission MDS assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. He was not known to display any behaviors or reject care during the seven days of the assessment period. He did not have any functional limitation in range of motion (ROM). He was dependent on staff for showers/bathing and required partial/moderate assistance for transfers.</p> <p>Review of Resident #9's care plan revealed he had a care plan in place for an impaired ability to perform or participate in daily ADL care related to a history of multiple fractures, muscle weakness, and abnormal posture. His goal was to participate with ADL's as much as possible and to have a neat appearance daily. The interventions included providing him assistance with ADL care as needed.</p> <p>Review of the Unit 2 shower schedule revealed Resident #9 was scheduled to receive a shower/bath every Tuesday, Thursday, and Saturday on the day shift.</p> <p>Review of Resident #9's shower documentation from 11/27/24 to 12/20/24 revealed the resident had no documented evidence of receiving showers or baths on 11/28/24, 11/30/24, 12/03/24, 12/05/24, 12/07/24, 12/10/24, 12/12/24, 12/14/24, 12/17/24, or 12/19/24, on his scheduled shower days. There was no evidence of the resident receiving a shower 10 out of 10 opportunities when a shower was scheduled. He was documented to have received showers on 12/04/24, 12/09/24, 12/13/24, and 12/18/24, which were non-scheduled shower days. There were six times out of the 10 showers that he should have received, in which no shower had been offered or provided.</p> <p>3. Review of Resident #30's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included hypertension, muscle weakness, abnormal posture, age-related osteoporosis, chronic pain syndrome, arthritis, and cataracts</p> <p>Review of Resident #30's admission 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 during the three days of the assessment period. She was not known to have any functional limitation in her range of motion. She required partial/moderate assistance for showers/baths and transfers.</p> <p>Review of Resident #30's active care plan revealed she had a care plan in place for an impaired ability to perform or participate in daily ADL's related to muscle weakness and chronic pain syndrome. The goal was for the resident to participate with ADL's as much as possible and to remain clean and dry, comfortable, and neat in appearance daily. The interventions included providing assistance with all ADL care as needed.</p> <p>Review of the Unit 1 shower schedule revealed Resident #30 was scheduled to receive showers every Tuesday, Thursday, and Saturday on the day shift.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #30's shower documentation from 12/02/24 until 12/23/24 revealed the resident was not documented as having received any showers/baths on 12/03/24, 12/07/24, 12/14/24, 12/17/24, or 12/19/24, which were all scheduled shower days. A bed bath was documented as having been provided on 12/12/24. Three showers were documented as having been given, out of the nine opportunities the resident was scheduled to receive one.</p> <p>On 12/23/24 at 11:01 A.M., an interview with Resident #30 revealed she did not get showers that often when she was scheduled to receive one. She confirmed the documentation of her showers seemed accurate in regards to her not receiving a shower five of the days she was scheduled to receive one. She denied that she had asked for a bed bath on 12/12/24, when it was documented as having been provided to her on a scheduled shower day. She denied that the staff typically asked if she wanted a shower, but reported the staff just come in and do what they want to do. It was her preference to receive showers and she stated she may only get one of the three showers that were scheduled for her each week.</p> <p>On 12/23/24 at 11:09 A.M., an interview with the facility's Director of Nursing (DON) confirmed the three residents (#3, #9, and #30) reviewed for showers were missing documented evidence of receiving a shower on their scheduled shower days and that the documentation that she had already provided was the only documentation they had. She stated the facility was in the process of hiring a new shower aide, with the current one moving back into working on the floor. The DON reported the shower aide was very busy and also helped out on the floor and that was why they could not get the scheduled showers completed when they had a shower aide. She stated they hoped by replacing their current shower aide with a new one, it would allow them to get the showers completed as scheduled.</p> <p>On 12/23/24 at 12:15 P.M., an interview with the facility's Administrator revealed the completion of resident's showers had been an ongoing issue. She reported the facility continued to work to get the issue resolved and it was a work in progress.</p> <p>Review of the facility's undated policy on Shower/Tub Baths revealed it was the facility's policy to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin. It stated the following information should be recorded on the resident's ADL record and/or in the resident's medical record: the date and the time the shower/tub bath was performed; the name and the title of the individual(s) who assisted the resident with the shower/tub bath; all assessment data obtained during the shower/tub bath; how the resident tolerated the shower/tub bath; if the resident refused the shower/tub bath, the reason(s) why and the intervention taken; and the signature and title of the person recording the data.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160691.</p>		