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 07/18/2024

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on record review and staff interviews, the facility failed to provide spend down notification for a resident who received Medicaid benefits. This affected one (#15) of five residents reviewed for funds. The facility census was 62. Findings include: Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including senile degeneration of brain, contracture of multiple muscle sites, dysphagia, schizoaffective disorder, depression, attention and concentration deficit, vascular dementia, and persistent mood disorder. Review of Resident #15's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS) assessment. She had a memory problem and severely impaired cognitive skills for daily decision making. Review of Resident #15's face sheet revealed she had a guardian. Review of Resident #15's order granting emergency guardianship revealed her current guardianship had been in place since 11/24/21. Review of Resident #15's quarterly statement dated 07/01/23 through 09/29/23 revealed an ending balance of $5,422.50. It was indicated this was mailed to guardian on 04/01/24. Review of Resident #15'2 quarterly statement dated 09/30/23 to 12/29/23 revealed an ending balance of $5, 598.63. It was indicated this was mailed to the guardian on 01/02/24. Review of Resident #15's quarterly statement from 03/30/24 to 06/28/24 revealed an ending balance of $5, 917.80. It was indicated this was mailed to the guardian on 07/02/24. (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: 365750	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #15's Resident Fund Balance Notification dated 07/01/24 revealed the letter was addressed to Resident #15 and indicated that her current resident fund balance was within $200 or exceeding what is allowable under medical assistance. The notification indicated the social worker should be contacted within the next seven days to discuss ways to assure continuance of Medicaid benefits. There was a place for a facility representative signature and resident acknowledgement but these were not filled out. Additionally, there was no information Resident #15's guardian received the notification. Review of the handwritten timeline by Social Service Coordinator #159, revealed in relation to Resident #15's account she had reached out to the guardian. On June 3rd (no year indicated) she reached out to the guardian about funeral arrangements. On June 13th (no year indicated) she left a voicemail related to funeral arrangements. On June 24th (no year indicated) she indicated papers were to be brought in related to funeral arrangements. On July 8th (no year indicated) papers were to be brought in. Interview on 07/18/24 at 7:55 A.M. with Social Service Coordinator #159 verified Resident #15 had exceeded the medicaid limit for funds for quite some time. SSC #159 revealed she had been speaking to Resident #15's guardian about her excessive funds since he took over at guardian. SSC #159 reported the money was supposed to go towards funeral arrangements, but he has not brought in the information to proceed with it. SSC #159 reported the guardian did not want the funds spent on anything but funeral arrangements but was unable to provide evidence of him saying this. SSC #159 reported her communications with the guardian were over phone calls and she did not think she had documentation to support her attempts to contact him.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to ensure care plans were implemented for all residents. This affected two (Residents #55 and #28) of 20 resident care plans reviewed. The census was 62. Findings Include: 1. Resident #55 was admitted to the facility on [DATE]. His diagnoses were unspecified fracture of T5-T6 vertebra, difficulty walking, muscle weakness, hyperlipidemia, acute respiratory failure, dysphagia, anemia, type II diabetes, atherosclerotic heart disease, hypertension, atrial fibrillation, acute embolism and thrombosis, bipolar disorder, heart failure, Parkinson's disease, acute kidney failure, anxiety disorder, sleep apnea, insomnia, polyneuropathy, conjunctivitis, and altered mental status. Review of facility Minimum Data Set (MDS) assessment, dated 06/15/24, revealed he was cognitively intact. Resident #55 was assessed to need partial/moderate assistance for toilet hygiene, upper/lower body dressing, and personal hygiene. Also, he was assessed as needed substantial/maximal assistance for showering and bathing. Review of Resident #55 current care plans revealed he had a care plan related to Activities of Daily Living (ADL) assistance that was started on 07/17/24, after it was requested for a copy of that care plan. There was no care plan developed for ADL assistance prior to 07/17/24. Interview with Assisted Director of Nursing (ADON) #124 on 07/17/24 at 1:45 P.M. confirmed there was no ADL care plan for Resident #55 until they created it on 07/17/24. She confirmed he needs assistance with his ADLs and should have had one. 43064 2. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including dysphagia, vascular dementia, chronic obstructive pulmonary disease, senile degeneration of brain, fibromyalgia, major depressive disorder, and contracture of muscle multiple sites. Review of Resident #28's quarterly MDS 3.0 assessment dated [DATE] revealed she was rarely or never understood. She was dependent on staff for eating. Review of Resident #28's plan of care revealed it did not address her hydration needs. Interview on 07/16/24 at 2:31 P.M. with the Administrator verified Resident #28 did not have plan of care for hydration.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observations, resident, family and staff interviews, and policy review, the facility failed to ensure residents, who required assistance from staff for personal care, received the assistance they needed to complete activities of daily living per the residents' preferences. This affected four (#20, #40, #55, and #264) of six residents reviewed for activities of daily living (ADL). The facility's census was 62. Findings include: 1. Review of Resident #40's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included low back pain, muscle weakness, difficulty walking, repeated falls, osteoarthritis, and unspecified dementia. Review of Resident #40's quarterly MDS assessment dated [DATE] revealed the resident did not have any communication issues and her cognition was coded as being moderately impaired. She was not known to display any behaviors and was not known to reject care. Her ADL function was not assessed as part of that quarterly MDS assessment. A prior admission MDS assessment dated [DATE] revealed the resident needed substantial/ maximal assistance with showers/ bathing. Review of Resident #40's care plans revealed she had a care plan in place for needing therapy services related to a decline in her prior level of function of ADL's. Interventions included providing the resident assistance as needed with ADL's. Review of the Unit 2 shower schedule revealed Resident #40 was to be a shower or bath on the 3:00 P.M. to 11:00 P.M. shift every. Showers or baths were to be done every Tuesday, Thursday, and Saturday. Review of Resident #40's shower and bathing documentation for the past 30 days revealed showers/ baths were documented on a Nursing Assistant Bathing/ Skin Tool (paper sheet) or in Point of Care History (electronic documentation) documented in the electronic medical record (EMR). Shower documentation from both sources were reviewed for the time period between 06/18/24 to 07/16/24. There was no documented evidence of the resident being given or offered a shower or other type of bathing activity on 07/06/24 or on 07/13/24. On 07/15/24 at 1:43 P.M., interview with Resident #40 revealed she was supposed to get showers three times a week. There were times she only got two showers a week. She reported it happened just the previous Thursday (07/11/24). She indicated there was only one aide on the floor and they did not have time to give her a shower. Further review of Resident #40's shower documentation on the Nursing Assistant Bathing Skin Tool revealed the resident was documented as having received a partial bed bath in her room on 07/11/24, when the resident alleged she did not get one due to staffing issues. The form indicated the partial bed bath was completed by State tested Nursing Assistant (STNA) #115. (continued on next page)

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F 0676

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Note: The nursing home is disputing this citation.

On 07/16/24 at 1:45 P.M., a follow up interview with Resident #40 confirmed the findings noted with review of her shower documentation and said that sounded about right. She confirmed she had likely missed a few of her showers on her scheduled shower days in the past 30 days. She was asked if she had been given a bed bath on 07/11/24 as was documented on the Nursing Assistant Bathing Skin Tool. She denied that a bed bath was even offered to her on 07/11/24, when she was not given a shower despite it being her scheduled shower day. She stated again they only had one aide on the floor on that day and she was told they did not have time to give her a shower.

On 07/16/24 at 2:20 P.M., interview with the Director of Nursing (DON) confirmed there was not any documented evidence of Resident #40 receiving a shower on 07/06/24 and 07/13/24. She stated she spoke to STNA #113, who claimed to have set the resident up with a wash basin on 07/06/24. She confirmed they did not have any documentation to support the resident had been offered a shower on 07/06/24 and refused explaining why STNA #113 would have set the resident up for a bed bath instead. She acknowledged it was the resident's preference to receive showers and confirmed showers should be given or at least offered on her scheduled days.

On 07/17/24 at 2:10 P.M. interview with STNA #115 revealed it was her initials that was written on the Nursing Assistant Bathing Skin Tool for 07/11/24 indicating a partial bed bath had been given to Resident #40 in her room. She reported those were her initials, but she did not fill the form out on that day. She also noted on that same form that she was documented as having provided a shower to the resident on 07/04/24. She denied she had given the resident a shower on that date and did not fill out the form to reflect that she had. She had been on a work restriction since 06/26/24. Her right arm had a hand wrist splint observed to be on it and she was not permitted to complete showers. She was on a light duty restriction and only assisted with activities such as passing out ice water and answering lights. She verbalized she was upset that someone would put her name on that form indicating something was done by her that she did not do.

07316

2. Review of the medical record for Resident #20 revealed an admitted [DATE] and diagnoses including diabetes, chronic obstructive pulmonary disease, and schizoaffective disorder.

Review of a Minimum Data Set assessment dated [DATE] revealed a brief interview for mental status score of 15, indicating intact cognition. It indicated the resident was frequently incontinent of bowel and bladder and required substantial maximal assistance with bathing.

Review of the plan of care dated 04/01/24 revealed to see resident profile for activity of daily living assistance needed. Review of the resident profile revealed Resident #20 required substantial maximal assistance with showers or bathing.

Interview with Resident #20 on 07/15/24 at 8:59 A.M. revealed one of her scheduled shower days was Saturday. She stated that she had not gotten a shower on Saturday (07/13/24) because the facility was short of help. She stated that this happens regularly on the weekends. She stated her last shower had been on Thursday (07/11/24) which was four days prior. She stated this bothered her and makes her feel awful not to get her scheduled showers. She stated the shower scheduled for Saturday was not given on a different day. The resident was observed, at that time, to have a dark material under her fingernails on both hands.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Observations on 07/15/24 at 11:50 A.M. and on 07/16/24 at 7:54 A.M. (while eating breakfast) revealed Resident #20 to have a dark material under her fingernails. Observations on 07/17/24 at 7:55 A.M. Resident #20 was eating breakfast in bed. She stated she was given a shower on 07/16/24 (Tuesday) but was still observed with a dark material under her fingernails. This was confirmed, at that time, by Registered Nurse (RN) #126. RN #126 stated the resident's fingernails should have been cleaned when she received a shower. She confirmed she would not want to eat with dark material under her fingernails. Review of the shower schedule for Resident #20 revealed she was scheduled for showers on Tuesday, Thursday, and Saturday. Review of nursing assistant bathing tools (shower records) for the past month for Resident #20 revealed a shower record dated 07/13/24, indicating the resident received a shower with fingernails cleaned on that day. The record stated the shower was completed by STNA #119. Interview with STNA #119 on 07/16/24 at 10:20 A.M. confirmed the STNA did not complete a shower for Resident #20 on 07/13/24. She stated she did not even work on that unit on 07/13/24. She stated staff did have difficulty getting showers done on Saturdays. She stated she did not complete a shower sheet for Resident #20 on that day. In addition, there was no evidence Resident #20 received a scheduled shower on 06/20/24, 06/29/24, or 07/06/24. Interview with the Administrator and Director of Nursing on 07/16/24 at 10:30 A.M. revealed they did not know why Nursing Assistant #119's name was written on the shower sheet for Resident #20 on 07/13/24 when she said she did not do the shower and the resident stated she did not receive a shower. 37100 3. Review of Resident #55's medical record reveaeled the resident was admitted to the facility on [DATE]. His diagnoses were unspecified fracture of T5-T6 vertebra, muscle weakness, Parkinson's disease, anxiety disorder, polyneuropathy, and altered mental status. Review of facility Minimum Data Set (MDS) assessment, dated 06/15/24, revealed he was cognitively intact was assessed to need partial/moderate assistance for toilet hygiene, upper and lower body dressing, and personal hygiene. Resident #55 needed substantial maximal assistance for showering and bathing. Review of Resident #55 shower forms, dated 05/13/24 to 07/12/24, revealed one instance on 06/03/24 in which it was documented that he was shaved. There was no other resident documentation to support if/when the facility shaved Resident #55 Observation of Resident #55 on 07/15/24 at 11:59 A.M. revealed he was not shaved. He had stubble on his face. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with Resident #55 on 07/15/24 at 11:59 A.M. revealed he would like more assistance with getting shaved. He does not like to have facial hair. He confirmed he currently has facial hair and did not get shaved last time he was showered. He stated he does not get asked very often if he would like to be shaved; he has to ask for it to be done during his shower days. Interview with Administrator on 07/17/24 at 9:45 A.M. confirmed there was no other documentation for Resident #55 to prove that he was offered and/or shaved each day that he took a shower with staff assistance. Interview with State tested Nursing Aide (STNA) #110 and STNA #113 on 07/17/24 at 1:04 P.M. confirmed they are to ask residents if they would like to be shaved during each of their shower days. They are to document when they shave a resident on the shower forms each time. If there is no documentation on the forms, they did not ask or actually shave a resident. They confirmed Resident #55 likes to be clean shaven and when they perform showers for him, they will ask him each time. 43064 4. Review of the medical record for Resident #264 revealed an admitted [DATE] with diagnoses including unspecified fracture of left femur, muscle weakness, dorsalgia, osteoarthritis, and unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #264's five-day MDS assessment dated [DATE] revealed she had severely impaired cognition. Review of Resident #264's plan of care dated 05/04/24 revealed Resident #264 had impaired ability to perform or participate in daily ADL interventions included providing nail care and shampooing hair with showers according to the weekly schedule, providing and assisting with daily care, offering assistance with clothes daily, and referring to therapy as needed. Review of Resident #264's physician order dated 05/22/24 revealed she was dependent for bathing and showering. Review of the shower schedule revealed Resident #264 was to receive showers on Tuesdays, Thursdays, and Saturdays. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #264's shower sheets from 06/01/2024 to 07/14/2024 revealed the resident did not receive a bath or shower as scheduled on 06/08/24, 06/15/24, 06/25/24, 06/29/24, and 07/06/24. On 06/04/24 it was indicated that therapy provided a shower, bath, or bed bath. The nurse initial was completed by the Director of Nursing (DON), the 06/04/24 bath/shower was written in the same writing as the initials. It was not specified who in therapy provided the bath or what was given. On 06/06/24 and 06/13/24 it was indicated that Resident #264 was given a partial bed bath. On 06/11/24 it was indicated therapy provided a bed bath. It was not specified who in therapy provided the bed bath. The nurse initial was completed by the DON, the 06/11/24 partial bed bath was written in the same writing as the initials. It was not specified who in therapy provided the bed bath. On 06/18/24 it was indicated therapy provided a partial bed bath. The nurse initial was completed by the DON, the 06/18/24 partial bed bath was written in the same writing as the initials. It was not specified who in therapy provided the bed bath. On 06/20/24 she was given a shower and on 06/22/24 she refused. On 06/26/24 it was indicated Resident #264 was given a bed bath. On 06/27/24 she was given a partial bed bath. The nurse initial was completed by the DON, the 06/27/24 partial bed bath was written in the same writing as the initials. On 07/02/24 Resident #264 received a partial bed bath. The nurse initial was completed by the DON, the 07/02/24 partial bed bath and the staff name was written in the same writing as the initials. On 07/04/24 Resident #264 received a shower from STNA #115. The nurse initial was completed by the DON, the 07/04/24 partial bed bath and the staff who completed it was written in the same writing as the initials. On 07/09/24 it was indicated therapy provided a bed bath. The nurse initial was completed by the DON, the 07/09/24 bed bath was written in the same writing as the initials. It was not specified who in therapy provided the bed bath. On 07/11/24 and 07/13/24 it was indicated Resident #264 refused a shower. Review of the electronic medical record revealed no additional baths or showers. The only documentation for baths or showers was completed by the STNA's on 06/06/24, 06/13/24, 06/20/24, 06/26/24, and 07/04/24. Interview on 07/16/24 at 1:10 P.M. with the DON revealed the normal procedure for showers is to have the nurse on duty sign the shower sheets to verify they were completed. She indicated she initialed the forms if the nurse did not. She verified that she completed many of the forms provided. She indicated she talked to the aides or reviewed the Electronic medical record to determine when showers had been completed. On 07/17/24 at 2:10 P.M. with STNA #115 revealed she had been on a work restriction since 06/26/24 and had not been permitted to complete showers. She was performing light duty including answering lights and passing out ice water. Interview on 07/16/24 at 2:20 P.M. with the DON and Administrator revealed therapy staff completed showers at times but did not document them. An undefined time later DON would interview the therapy staff to determine when they were completing showers. The DON verified which therapy staff were completing the showers was not indicated. Evidence that the missing showers were completed was requested, and no additional shower sheets were provided. Interview on 07/18/24 at 10:12 A.M. with the DON and Administrator revealed the DON obtained residents shower and bathing schedules and put them on the shower schedule. The shower schedule was set up according to residents' preferences.

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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** 50008 Based on record review, observations, resident, family and staff interviews, and policy review, the facility failed to ensure residents, who were dependent on staff for personal care, received the assistance they needed to complete activities of daily living per the residents' preferences. This affected one (#7) of six residents reviewed for activities of daily living (ADL). The facility's census was 62. Findings Include: Resident #7 was admitted on [DATE] with diagnoses that included toxic encephalopathy, muscle weakness, schizoaffective disorder, polyneuropathy, autonomic dysreflexia, contracture of muscles multiple sites, quadriplegia, and spondylosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #7 had a Brief Interview Mental Status (BIMS) of 12, indicating moderate impairment of cognition. Further review of Resident #7's assessment revealed that she was dependent for showering and bathing. Interview with Resident #7 on 07/15/24 at 10:28 A.M. revealed that Resident #7 prefers three showers weekly and that she felt that she had not been receiving three showers weekly. Specifically, Resident #7 stated that she had not been showered on Saturday, 07/13/24. Review of Shower sheets revealed that Resident #7 had refused a shower on 07/13/24. The shower sheet for 07/13/24 indicated that it had been signed by STNA #122. Interview with STNA #122 on 07/15/24 at 10:28 A.M. revealed that STNA #122 called off work on 07/13/24 due to illness. STNA #122 stated that she did not fill out a shower sheet on 07/13/24, nor did she offer Resident #7 a shower on 07/13/24 since she was not at the facility on that date. Review of timeclock records for Saturday 07/13/24 revealed that STNA #122 07/13/24 was scheduled on that date, but she did not work at the facility on 07/13/24. Interview with Staff Coordinator #171 on 07/17/24 at 12:28 P.M. confirmed that STNA #122 had called off ill on 07/13/24 and did not work at the facility on that date. The facility failed to produce further evidence that Resident #7 was showered on 07/13/24, per her preference. Review of the Shower policy revised on 04/18/24 stated that it is the facility's policy to promote cleanliness and provide comfort to the resident. The following information should be recorded on the resident's bath sheet: the date the shower/tub bath was performed by staff or refused by resident; if the resident refused the shower/tub bath, the reason why and the intervention taken; The name of the individual who assisted with/offered the resident the shower/tub bath.

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F 0684 Level of Harm - Minimal harm or potential for 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** 07316 Based on observations, medical record review, and staff interview, the facility failed to ensure a resident was properly positioned in a wheelchair. This affected one (Resident #25) of three residents reviewed for positioning. The facility census was 62. Findings include: Review of the medical record for Resident #25 revealed an admitted [DATE] and diagnoses including spastic quadriplegia, cerebral palsy, traumatic brain injury, and scoliosis. Review of the Minimum Data Set assessment dated [DATE] revealed a brief interview for mental status score of 7, indicating severe cognitive impairment. Resident #25 had impairment in range of motion bilaterally, was unable to walk, and was dependent for all activities of daily living. Review of physician orders revealed the resident had a physician's order dated 03/12/23 for a dycem mat to the wheelchair seat to prevent sliding. Review of an occupational therapy discharge summary dated 04/24/24 revealed on 02/28/24 a new custom wheelchair was obtained. On 03/27/24 the note indicated recent modifications provided to custom wheelchair to facilitate safe and upright seating as patient continues to slide forward at times. Requires verbal cues to lock brakes and reposition self, but is able to with multiple verbal cues and extended time with physical assist required at times. On 04/24/24 the note stated the same as 03/27/24. It also stated positioning had significantly improved, however not on a consistent basis. Observations on 07/16/24 at 7:45 A.M. revealed Resident #25 to be in a wheelchair in the dining room for breakfast. He was slid down in the wheelchair and his head was not positioned on the head rest of the custom wheelchair. He was also leaning to the left. Interview with State tested Nursing Assistant (STNA) #133 at the time of this observation confirmed Resident #25 had received the custom wheelchair 3-4 months prior but it did not keep him from sliding down in the wheelchair. The STNA verified his head was not in the custom head rest. She stated she thought he had a back issue that prevented him from sitting upright and he leans to the left. Observations on 07/17/24 at 8:00 A.M. revealed Resident #25 to be in the custom wheelchair in the hallway. He was using his feet to propel the wheelchair and had slid down in the chair to where his bottom was near the edge of the wheelchair seat. He was not observed to have the dycem mat in the wheelchair seat. This was confirmed by Registered Nurse #126 at the time of the observation. She confirmed the resident had a physician's order to have a dycem mat in the wheelchair and did not. Interview with Resident #25's brother on 07/15/24 at 2:30 P.M. revealed the resident got the new wheelchair in February 2024. He stated he had not been satisfied with it as it does not work well for his positioning. Interview with Occupational Therapist #201 on 07/16/24 at 8:33 A.M. confirmed Resident #25 got the new custom wheelchair on 02/28/24. She stated he has scoliosis in his back and leans to the left. She stated that he uses his feet to propel the wheelchair and this pulls him down in the chair. She confirmed modifications had been made to the wheelchair in March and April 2024, but not since. (continued on next page)

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	365750	A. Building B. Wing	07/18/2024

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence of any further attempts to improve Resident #25's positioning in the wheelchair.

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on medical record review, observations, and staff interview, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections. This affected two of two residents reviewed for urinary tract infections (Residents #8 and #20) in a sample of 24. The facility census was 62. Findings include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE] and diagnoses including cerebral infarction with hemiplegia, diabetes, history of urinary tract infections with ESBL resistance. Review of a Minimum Data Set assessment completed 05/10/24 revealed a brief interview for mental status score of 11, indicating moderately impaired cognition. The resident was frequently incontinent of bowel and bladder and was dependent upon staff for toileting hygiene. Review of the plan of care dated 09/13/23 revealed the resident was incontinent of bowel and bladder and was at risk for skin breakdown and urinary tract infections. Incontinence care was to be provided as needed. Review of Resident #8's urine culture on 03/23/24 revealed positive results of greater than 100,000 Escherichia coli. (Escherichia coli is present in stool and can get into the urinary tract without proper hygiene). A physician's order was obtained for an antibiotic (Macrobid 100 milligrams twice daily for seven days). Review of the medication administration record revealed the antibiotic was started on 03/25/24 and continued until 04/02/24 for a total of 17 doses (14 ordered). Observations of incontinence care for Resident #8 on 07/17/24 at 12:50 P.M. revealed the resident to be in bed. The resident's incontinence brief was wet with urine. State tested Nursing Assistant (STNA) #150 was preparing to provide the incontinence care. STNA #150 stated the facility was out of wet wipes to cleanse the resident's perineal area. The resident stated don't leave me wet. STNA #150 was observed to remove the wet incontinence brief and use dry toilet paper to wipe the resident's perineal and rectal area. The toilet paper had smears of bowel movement on it after the STNA wiped Resident #8. A clean incontinence brief was then applied. The resident's perineal area and rectal area were not cleansed after being incontinent of bladder and bowel. After the care was provided, Nursing Assistant #150 stated she did not consider using a washcloth and soap and water to cleanse the resident's skin because she felt it would be too rough on her skin, and confirmed the resident was not cleansed. Review of the facility undated policy on perineal care revealed it was the facility policy to provide cleanliness and comfort to the resident and to prevent infections and skin irritation. The policy stated to fill a wash basin half full of warm water. Wet a washcloth and apply soap. Wash the perineal area and then rinse thoroughly using fresh water and a clean washcloth. Rinse the wash cloth and apply soap. Wash the rectal area thoroughly and then rinse. (continued on next page)

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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	Interview with the Director of Nursing on 07/17/24 at 1:09 P.M. revealed either wet wipes or a wash cloth with soap and water should be used to cleanse a resident's skin during incontinence care to remove urine and bowel movement from the resident's skin. The DON also confirmed Resident #8 received a total of 17 doses of Macrobid 100 mg and not the 14 doses that were ordered to treat the UTI on 03/25/24. 2. Review of the medical record for Resident #20 revealed an admitted [DATE] and diagnoses include diabetes, chronic obstructive pulmonary disease, and schizoaffective disorder. Review of a Minimum Data Set assessment dated [DATE] revealed a brief interview for mental status score of 15, indicating intact cognition, the resident was frequently incontinent of bowel and bladder. Review of nursing progress notes revealed on 05/19/24 at 1:59 P.M. the resident's daughter said the resident was confused at times and she wanted to know if a urinalysis could be done. On 05/21/24 at 4:15 P. M. it was documented that a new order was received for a urinalysis and culture and sensitivity testing. On 05/26/24 at 3:15 P.M. it was documented that the urine test results were received, the physician was notified, and orders were received for an antibiotic daily for seven days. Review of urine culture and sensitivity results revealed on 05/24/24 the resident was noted to have >100,000 Escherichia coli in the urine. It was written on the results to give an antibiotic (Bactrim DS 800-160 twice daily for seven days (14 doses). Review of the medication administration record revealed the antibiotic was given in the evening on 05/26/24. The resident did not receive the antibiotic in the morning of 05/27/24. The medication was then restarted on 05/27/24 in the evening, at the twice daily cadence. The MAR revealed Resident # 20 received a total of 12 doses of Bactrim DS and the medication and not the ordered 14 doses. The Bactrim DS was discontinued on 06/01/24. Interview with the Director of Nursing on 07/16/24 at 10:30 A.M. confirmed Resident #20 did not receive the full ordered dose of antibiotics. She confirmed the resident should have received 14 doses and only received 12.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on record review and interview the facility failed to provide evidence that urostomy care was completed as care planned and ordered for Resident #47. This affected one resident (#47) of one resident reviewed for urostomy care. The facility census was 62. Findings include: Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses including chronic kidney disease, unspecified dementia, unspecified mood disorder, obstructive and reflux uropathy, anxiety disorder, major depressive disorder, unspecified hearing loss, and malignant neoplasm of bladder. Review of Resident #47's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition and had an ostomy. Review of Resident #47's plan of care dated 01/27/23 revealed the resident had an alteration in elimination related to urostomy. Interventions included keeping drainage bag below bladder and off the floor, using leg strap to prevent tubing from pulling, changing catheter bag per policy, irrigating per physician's order, and urostomy care every shift and/or per policy. Review of Resident #47's physician order dated 01/11/23 revealed an order for ostomy care every shift and as needed. Review of Resident #47's physician's orders revealed no orders related to irrigating the tubing or changing the catheter bag. Review of Resident #47's Medication Administration Record (MAR) from 04/16/24 to 07/14/24 revealed no evidence that ostomy care was completed as ordered. Interview on 07/16/24 at 4:39 P.M. and 4:51 P.M. with the Administrator revealed the only documentation related to Resident #47's ostomy care was output monitoring. She verified there was no documented evidence that urostomy care was completed as ordered and care planned.

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43064

Based on medical record review, interview, and review of facility policy, the facility failed to develop and implement a comprehensive, effective and individualized nutritional program to ensure nutritional recommendations were implemented timely, weights and assessments were completed timely, care plans were updated appropriately, and significant/severe weight changes were addressed for Resident #264.

Actual harm occurred when Resident #264 who was cognitively impaired and weighed 104 pounds on 05/19/24 experienced a gradual weight loss until 06/24/24 when she experienced a severe 8.5% (9 pounds) weight loss. The nutritional recommendations for Resident #264 that were made on 05/19/24 were not put in place until they were recommended again on 06/09/24. A nutritional assessment was not completed again following the 06/09/24 recommendation, and as of 07/18/24 Resident #264 weighed 93.8 pounds which was severe 6.7% (6.8 pound) weight loss from 06/20/24.

This affected one resident (#264) of two residents reviewed for nutrition. The facility census was 62.

Findings include:

Review of the medical record for Resident #264 revealed an admitted [DATE] with diagnoses including unspecified fracture of left femur, metabolic encephalopathy, muscle weakness, anorexia, dorsalgia, anemia, protein-calorie malnutrition, depression, osteoarthritis, and unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

Review of Resident #264's census revealed she was admitted on [DATE] with hospice services. The resident was discharged on [DATE] with return expected and returned on 05/13/24 without hospice. Resident #264 was discharged again on 05/19/24 with return expected and she returned on 05/21/24.

Review of Resident #264's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. The assessment revealed the resident was 59 inches tall and weighed 104 pounds. Resident #264 was on a regular diet.

Review of Resident #264's weights revealed there were no documented weights from 05/08/24 to 05/18/24. On 05/19/24 Resident #264 weighed 104 pounds.

Review of Resident #264's nutrition assessment revealed the dietician completed one assessment for the resident which was dated 05/19/24. The assessment revealed the resident was on a regular diet and had varied intake. The dietitian recommended a house supplement twice a day for additional nutritional support. The goal was for the

resident to be hydrated and nourished as her condition allowed.

Review of an email dated 05/19/24 (provided 07/18/24 at 11:27 A.M.) revealed Dietitian #199 informed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #124 that she recommended starting Resident #264 on house supplement twice a day.

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the physician's orders for Resident #264 from 05/19/24 to 06/05/24 revealed no orders for house supplement. Review of the physician's orders for Resident #264 revealed an order dated 05/21/24 for a regular diet. Additionally, there was a new order for weekly weights from 05/21/24 to 06/18/24. Review of Resident #264's weights revealed on 05/22/24 she weighed 140.2 pounds and on 05/24/24 she weighed 104.2 pounds. Review of Resident #264's progress note dated 05/24/24 revealed her weight had been obtained and the weight of 140.2 pounds was incorrect her weight was 104.2 pounds. Review of Resident #264's weights revealed on 05/28/24 she weighed 93 pounds. Review of the medical record revealed no evidence a reweigh was obtained at this time. Review of Resident #264's progress note dated 06/05/24 revealed Dietitian #199 reviewed weights and a weekly weight update was requested. The resident's most recent weight was showing a weight change since admission. The resident had variable oral intakes. Dietitian #199 recommended beginning four ounces of the house supplement twice a day for additional nutritional support. Review of the email dated 06/05/24 (provided on 07/18/24 at 11:31 A.M.) revealed Dietitian #199 informed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #124 that she needed a weekly weight on Resident #264 because of a weight change since admission. She also recommended beginning her on four ounces of house supplement twice a day. Dietitian #199 indicated this had been recommended previously and had been missed. Review of Resident #264's physician order dated 06/06/24 revealed an order for house supplement four ounces twice a day. Review of Resident #264's Medication Administration Record (MAR) from 06/06/24 to 07/14/24 revealed the house supplement did not have any indication of how much of the supplement the resident accepted. Resident #264 had refused the supplement on 07/01/24 and 07/03/24. Review of Resident #264's weights revealed on 06/07/24 she weighed 102.8 pounds, on 06/09/24 she weighed 101.2 pounds, on 06/20/24 she weighed 100.6 pounds, on 06/24/24 she weighed 95 pounds, and on 07/01/24 she weighed 95.4 pounds. Her 07/01/24 weight was a severe 7.2% weight loss thirty days. Review of Resident #264's plan of care dated 06/10/24 revealed the resident was at risk for altered nutrition related to a hip fracture with surgical wound and diagnoses. She was receiving hospice care and was to receive no routine weights for comfort. The plan of care revealed Resident #264 might not meet her estimated needs related to likely decline in condition or intakes. She was receiving a regular diet with variable intakes. House supplement was recommended twice a day, and the resident was receiving the medication Mirtazapine which might act as an appetite stimulant. Interventions included offering menu alternatives as needed, honoring food preferences, and not completing routine weights related to comfort measures, and providing the diet and supplements as ordered. Review of Resident #264's progress note dated 07/15/24 revealed a new order was received to continue weekly weights. (continued on next page)

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #264's weights revealed a weight on 07/17/24 of 92.2 pounds and a weight on 07/18/24 of 93.8 pounds which was a severe 6.7% (6.8 pound) weight loss over thirty days. Review of Resident #264's medical record revealed Dietician #199 documented a nutritional assessment for Resident #264 on 05/19/24 and a progress note for the resident on 06/05/24 and no other documentation from the dietician was present in the medical record. Interview on 07/17/24 at 3:01 P.M. and 3:20 P.M. with Dietitian #199 revealed she worked six to twelve hours a week remotely for the facility. She reported she monitored significant weight changes weekly on Saturday by running a significant weight change report. Dietitian #199 indicated that when a resident had significant weight loss, she put them on weekly weights and monitored the weight weekly until the weight loss was corrected. She reported she was not always sure what was going on with residents and would ask staff for updates. Dietitian #199 revealed weights were supposed to be obtained within a week of admission. Dietitian #199 indicated she was unsure when Resident #264 was removed from hospice Dietitian #199 indicated Resident #264 was supposed to be getting weekly weights and had never been removed from the list. Dietitian #199 indicated she was not aware why the supplement as recommended on 05/19/24 had not been implemented. Dietitian #199 also indicated that supplement documentation should include percentages as she uses it in nutrition assessments. The last time Resident #264 was assessed was 06/05/24. Interview on 07/18/24 at 8:35 A.M. with the Director of Nursing (DON) confirmed the supplement did not get put in place for Resident #264 on 05/19/24 because she went out to the hospital that day. It did not get started when she returned on 05/21/24 but was implemented after the dietitian recommended it again on 06/05/24. Interview on 07/19/24 at 9:50 A.M. with the Administrator confirmed Resident #264's nutrition plan of care was incorrect as she stopped receiving hospice care on 05/13/24.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, medical record review, resident and staff interview, review of staffing schedules, and policy review, the facility failed to have sufficient staff to meet the needs of each resident. This affected three of 24 sampled residents (Residents #7, #20, and #40). The facility census was 62. Findings include: 1. Review of the medical record for Resident #20 revealed an admitted [DATE] and diagnoses including diabetes, chronic obstructive pulmonary disease, and schizoaffective disorder. Review of a Minimum Data Set assessment dated [DATE] revealed a brief interview for mental status score of 15, indicating intact cognition. It indicated the resident required substantial/maximal assistance with bathing. Review of the plan of care dated 04/01/24 revealed Resident #20 required substantial/maximal assistance with shower/bathing. Review of the shower schedule for Resident #20 revealed she was scheduled for showers on Tuesday, Thursday, and Saturday. Review of medical record revealed there was no evidence Resident #20 received a scheduled shower on Thursday 06/20/24, Saturday 06/29/24, or Saturday 07/06/24. Interview with Resident #20 on 07/15/24 at 8:59 A.M. revealed one of her scheduled shower days was Saturday. She stated that she had not gotten a shower on Saturday (07/13/24) because the facility was short of help. She stated that this happens regularly on the weekends. She stated her last shower had been on Thursday (07/11/24) which was four days prior. She stated this bothered her and makes her feel awful not to get her scheduled showers. She stated the shower scheduled for Saturday was not given on a different day. The resident was observed, at that time, to have a dark material under her fingernails on both hands. Interview with the Administrator and Director of Nursing on 07/16/24 at 10:30 A.M. confirmed the resident did not receive a shower on 07/13/24. 28923 2. Review of Resident #40's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included low back pain, muscle weakness, difficulty walking, repeated falls, osteoarthritis, and unspecified dementia. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #40's quarterly MDS assessment dated [DATE] revealed the resident coded as having moderate cognitive impairment. She was not known to display any behaviors and was not known to reject care. Her ADL function was not assessed as part of that quarterly MDS assessment. A prior admission MDS assessment dated [DATE] revealed the resident needed substantial/ maximal assistance with showers/ bathing. Review of Resident #40's care plans revealed she had a care plan in place for an impaired ability to perform ADL's due to difficulty walking and impaired wheelchair mobility. Interventions included providing the resident assistance as needed with ADL's. Review of the Unit 2 shower schedule revealed Resident #40 was to receive a shower or bath on the 3:00 P. M. to 11:00 P.M. shift on Tuesday, Thursday, and Saturday. Review of Resident #40's shower/ bathing documentation for the past 30 days revealed there was no documented evidence of the resident being given a shower or other type of bathing activity on 07/06/24 or on 07/13/24 (both Saturdays) on her scheduled shower day. On 07/15/24 at 1:43 P.M., interview with Resident #40 revealed she was supposed to get showers three times a week, but there were times she only got two a week. She reported it happened just the previous Thursday (07/11/24). She indicated there was only one aide on the floor and they did not have time to give her a shower. Further review of Resident #40's shower documentation on the Nursing Assistant Bathing/ Skin Tool revealed the resident was documented as having received a partial bed bath in her room on 07/11/24 in place of a shower confirming Resident #40's reports of not receiving a shower on her scheduled shower day. On 07/16/24 at 1:45 P.M., a follow up interview with Resident #40 confirmed the findings noted with review of her shower documentation sounded about right in regards to the number of showers she was given during that 30 day period. She stated it was likely that she did miss a few of her showers on her scheduled shower days over the past 30 days. She was then asked if she had been given a bed bath on 07/11/24, as was documented on the Nursing Assistant Bathing/ Skin Tool. She denied that a bed bath was even offered to her on 07/11/24 (Thursday), when she did not get her shower. She stated again there was only one aide on the floor that day and she was told they did not have time to give her a shower. On 07/16/24 at 2:20 P.M., an interview with the Director of Nursing (DON) confirmed there was not any documented evidence of Resident #40 receiving a shower on 07/06/24 and 07/13/24 (one of her three scheduled shower days over the course of a week). She stated she spoke to a STNA (STNA #113), who claimed to have set the resident up with a wash basin on 07/06/24. She confirmed they did not have any documentation to support the resident had been offered a shower on 07/06/24 and refused that explained why STNA #113 would have set the resident up for a bed bath on that day instead of giving her a shower as scheduled. She acknowledged it was the resident's preference to receive showers and showers should be given or at least offered on her scheduled days. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 at 2:10 P.M., an interview with STNA #115 revealed it was her initials that was written on the Nursing Assistant Bathing/ Skin Tool for 07/11/24 indicating a partial bed bath had been given to Resident #40 in her room. She reported those were her initials, but she did not fill that form out on that day. She also noted on the same form that she was documented as having provided a shower to the resident on 07/04/24. She denied she had completed the shower documentation for that date either. She indicated she had been on a work restriction since 06/26/24. Her right arm had a hand/ wrist splint on it and she was not permitted to complete showers. She was on a light duty restriction and only assisted with activities such as passing out ice water and answering lights. She verbalized she was upset that someone would put her name on that form indicating something was done by her that she did not do. She reported she only floated between the two units on 07/11/24 and could not say for sure if showers were not completed due to staffing issues on that day. 50008 3. Resident #7 was admitted on [DATE] with diagnoses that included toxic encephalopathy, muscle weakness, schizoaffective disorder, depression, bipolar disorder, polyneuropathy, autonomic dysreflexia, contracture of muscles multiple sites, quadriplegia, and spondylosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #7 had a Brief Interview Mental Status (BIMS) of 12, indicating moderate impairment of cognition. Further review of Resident #7's assessment revealed that she was dependent for showering and bathing. Interview with Resident #7 on 07/15/24 at 10:28 A.M. revealed that Resident #7 prefers three showers weekly and that she felt that she had not been receiving three showers weekly. Specifically, Resident #7 stated that she had not been showered on Saturday, 07/13/24. Resident #7 stated that there was not enough staff that day to offer her a shower. Review of Shower sheets revealed that Resident #7 had refused a shower on 07/13/24. The shower sheet for 07/13/24 indicated that it had been signed by State tested Nursing Assistant (STNA) #122. Interview with STNA #122 on 07/15/24 at 10:28 A.M. revealed that STNA #122 called off work on 07/13/24 due to illness. STNA #122 stated that she did not fill out a shower sheet on 07/13/24, nor did she offer Resident #7 a shower on 07/13/24 since she was not at the facility on that date. Review of timeclock records for Saturday 07/13/24 revealed that STNA #122 was scheduled on that date, but she did not work at the facility on 07/13/24. Interview with Staff Coordinator #171 on 07/17/24 at 12:28 P.M. confirmed that STNA #122 had called off ill on 07/13/24 and did not work at the facility on that date. The facility failed to produce further evidence that Resident #7 was showered on 07/13/24, per her preference. Review of the facility working schedule revealed that there were more direct care staff that actually worked during the weekdays than on the weekends. (continued on next page)

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	07/18/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 07/17/24 at 2:37 P.M. confirmed that staffing on the weekends is less than during the weekdays. The Administrator stated that if the STNAs may not honor shower preferences if medical needs are prioritized. Administrator confirmed that there were many direct care call-offs on 07/13/24. This citation represents noncompliance investigated under OH00155741.

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 07/18/2024

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interviews, the facility failed to ensure routine laboratory testing was completed weekly as ordered by the physician. This affected one (#61) of five residents reviewed for unnecessary medications. The facility census was 62. Findings include: Review of Resident #61's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included sepsis, Methicillin- Resistant Staphylococcus Aureus (MRSA) infection in a diabetic ulcer of her left foot, and adult onset diabetes mellitus. Review of Resident #61's physician's orders revealed the resident had an order to receive Vancomycin 1,750 milligrams intravenously (IV) twice a day from 06/20/24 through 07/22/24. The physician's orders also included an order to obtain a complete blood count (CBC) with differential, sedimentation (sed) rate, C-Reactive Protein (CRP), and a Vancomycin trough level once a day on Tuesdays. That order had been in place since 06/24/24. Review of Resident #61's laboratory test results scanned into the electronic medical record (EMR) revealed no evidence of any of the labs that was ordered to be done weekly on Tuesday had been drawn on 07/09/24 or 07/16/24. On 07/17/24 at 3:43 P.M., an interview with the Director of Nursing (DON) revealed Resident #61 was out for an appointment on 07/09/24 and 07/16/24, when the laboratory technician was there to draw the labs. The DON confirmed the facility's nurses were able to draw blood if needed. The DON could not explain why the lab tests ordered to be done weekly on 07/09/24 was not obtained when Resident #61 returned to the facility later that same day or the following day. The DON stated the lab for 07/16/24 was scheduled to be obtained on 07/18/24. On 07/17/24 at 3:47 P.M., the Administrator brought a copy of a lab results for a CBC with Diff, CRP, and Renal panel that had been collected on 07/16/24. It did not include a sed rate or Vancomycin trough level as ordered. It was not clear where the lab had been obtained or why it was missing the sed rate and Vancomycin trough level. The Administrator denied she was able to find evidence of the labs being drawn on or around 07/09/24 as ordered. The Administrator acknowledged the facility was not obtaining labs on Resident #61 as ordered by her physician.