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	02/26/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and facility policy review, the facility failed to ensure resident equipment was maintained in a clean and sanitary manner. This affected three residents (#9, #44 and #54) of 25 sampled residents. The facility census was 69. Findings Include:1. Review of the medical record for Resident #44 revealed an initial admission date of 08/20/23 with the latest readmission of 05/21/24 diagnoses included the protein calorie malnutrition, urinary tract infection (UTI), depression, mood disorder, hypothyroidism, anemia, metabolic encephalopathy, solitary pulmonary nodule, chronic pain, atrial fibrillation, anorexia, osteoarthritis, dementia, macular degeneration and cerebral atherosclerosis. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Observation of Resident #44 on 02/23/26 at 10:58 A.M., revealed Resident #44's custom wheelchair was extremely dirty with food debris in the crevasses of the wheelchair and visible dirt all over the wheelchair. Interview with Licensed Practical Nurse (LPN) # 161 on 02/26/26 at 11:23 A.M., verified the resident's wheelchair was extremely dirty with food debris in the crevasses of the wheelchair and visible dirt all over the wheelchair. 2. Review of the medical record for Resident #54 revealed an initial admission date of 09/15/22, diagnoses included but were not limited to chronic kidney disease, intellectual disabilities, dysphagia, depression, anxiety disorder, obesity, hypothyroidism, osteoporosis, scoliosis, mixed incontinence, hypertension, migraine, insomnia and hyperlipidemia. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Observation on 02/23/26 at 1:11 P.M., revealed the resident's wheelchair with custom padded armrests was extremely dirty with visible dirt and dried food on custom padded armrests. Interview with LPN #161 on 02/26/26 at 11:23 A.M., verified the resident's wheelchair was extremely dirty with visible dirt and dried food on custom padded armrests. 3. Review of medical record for Resident #9 revealed an admission date of 12/13/23 and a readmission date of 11/17/25, diagnoses included Parkinson's disease, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) dated [DATE] revealed Resident #34 had a Brief Interview Mental Status (BIMS) score of 15 indicating no impaired cognition and she was receiving oxygen therapy. Review of the physician's orders dated 11/26/25 revealed oxygen two to four liters via nasal cannula to maintain saturations above 90 percent (%) every shift. Observation on 02/25/2026 at 10:11 A.M. of Resident #9's oxygen concentrator revealed a dried brown substance covering the front of the concentrator. Interview and observation on 02/25/26 at 10:31 A.M. with Registered Nurse (RN) #209 verified the dried brown substance covering the front of the oxygen concentrator. Interview with Environmental Service Coordinator #133 on 02/25/26 at 10:35 A.M. revealed the expectation for cleaning medical equipment is at least twice weekly or as needed. Review of facility policy titled Housekeeping Care and Cleaning of Equipment dated 07/01/25, revealed equipment will be cleaned and maintained in a sanitary condition to prevent the spread of infectious disease.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and family interview, the facility failed to honor a resident's stated beverage preference. This affected one, (Resident #22) of two residents reviewed for choices. The facility census was 69. Findings include:Review of Resident #22's medical record revealed the resident was admitted on [DATE] with diagnoses including dementia and chronic kidney disease. Review of the the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively impaired, and required supervision and assistance with eating and drinking. Resident #22 relied on staff to ensure adequate hydration was maintained.Review of the facility document titled Resident Centered Care Food Preferences revealed juice was identified as the resident's preferred beverage at meals. There was no documentation indicating the resident preferred water over juice. During an interview on 02/23/26 at 10:45 A.M., Resident #22's daughter and Power of Attorney (POA) revealed the resident does not want water to drink and prefers juice. The POA stated staff continued to provide water despite the resident's stated preference and expressed concern the preference was not consistently honored.On 02/23/26 at 10:30 A.M., Resident #22 was observed seated in his room. A clear plastic cup containing water was on the bedside table within reach. No juice or other beverages were observed.On 02/24/26 at 9:15 A.M., Resident #22 was observed during the breakfast meal period. The meal tray was present in the room, and no additional beverage was noted on the tray. A hospital mug containing water was observed at bedside. No juice or other preferred beverage was present.On 02/25/26 at 1:30 P.M., Resident #22 was observed during the lunch meal period. The meal tray was present, and no additional beverage was noted on the tray. The resident had only a cup of water available. No juice or other preferred beverage was observed.During an interview on 02/23/26 at 9:15 A.M., Licensed Practical Nurse (LPN) #161 stated she was not aware Resident #22 preferred juice and did not want water. LPN #161 stated staff typically provided fluids available on the unit and was unaware of a documented preference indicating juice should be offered instead of water.During an interview on 02/23/26 at 1:40 P.M., Certified Nursing Assistant (CNA) #131 stated she was not aware Resident #22 preferred juice and did not want water. CNA #131 stated she provided fluids available during meal service and throughout the shift and had not been informed of a specific instruction to offer juice instead of water.During an interview on 02/24/26 at 10:05 A.M., CNA #139 revealed she was not aware Resident #22 preferred juice and did not want water and reported staff provide fluids available on the unit unless otherwise directed.Review of the facility policy regarding resident-centered care and food preferences revealed fluids are to be provided based on resident preferences.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and review of facility policy review, the facility failed to ensure the baseline care plan was timely reviewed and provided to one ((Resident #74) of 24 residents reviewed. The census was 69.Findings include:Review of Resident #74's medical record revealed the resident was admitted on [DATE] with diagnoses including hypertensive emergency, repeated falls, dementia, and major depressive disorder.Review of the admission Nursing assessment dated [DATE] revealed an unsigned Baseline Care Plan dated 01/28/26. There was no evidence that the resident was provided with the baseline care plan or that it had been reviewed with her or the resident representative.Review of the initial Resident Care Conference dated 02/03/26 revealed no evidence the resident or resident representative was provided with a copy of the baseline care plan.Review of the care conference progress notes authored by Social Services Coordinator #178 dated 02/03/26 revealed current medications, all orders, care plan, and progress with therapy was discussed at the care conference.Interview on 02/24/26 at 2:50 P.M. with Regional Nurse #225 verified Resident #74 had not been provided with a copy or explained the baseline care plan during the required time frame.Review of facility policy title Care Planning-Comprehensive, dated 05/01/25 revealed A baseline care plan is completed upon admission (within 48 hours) based on data.

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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** Based on record review, observation, interview, and facility policy review, the facility failed to develop and implement a person-centered comprehensive care plan for one, (Resident #22) of 24 residents reviewed. The facility census was 69.Findings include:Findings include:Review of Resident #22's medical record revealed the resident was admitted on [DATE] with diagnoses including dementia and chronic kidney disease.Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively impaired reflected cognitive impairment and needed for supervision and assistance with eating and drinking. The MDS revealed Resident #22 required staff assistance to ensure adequate hydration.During an interview on 02/23/26 at 10:45 A.M., Resident #22's daughter and Power of Attorney (POA) stated the resident does not want water to drink and prefers juice. The POA stated staff continued to provide water despite the resident's stated preference.Review of the facility document titled Resident Centered Care Food Preferences revealed juice was identified as the resident ' s preferred beverage at meals. There was no documentation indicating the resident preferred water over juice.Review of the comprehensive care plan revealed the resident required assistance with activities of daily living and to monitor intake. The care plan did not include a person-centered intervention identifying the resident's preference for juice instead of water, nor did it include measurable objectives or direction to staff to provide fluids consistent with the resident's stated preference.On 02/23/26 at 10:30 A.M., Resident #22 was observed in his room with a clear plastic cup containing water on the bedside table within reach. No juice or alternative fluids were present.On 02/24/26 at 9:15 A.M., Resident #22 was observed in his room with a cup of water present. No other beverages were observed.On 02/25/26 at 1:30 P.M., Resident #22 was observed in his room with a cup of water present. The resident was not observed being offered juice.During an interview on 02/23/26 at 9:15 A.M., Licensed Practical Nurse (LPN) #161 stated she was not aware Resident #22 preferred juice and did not want water.During an interview on 02/23/26 at 1:40 P.M., Certified Nursing Assistant (CNA) #131 stated she was not aware Resident #22 had a documented preference for juice over water.During an interview on 02/24/26 at 10:05 A.M., CNA #139 stated she had not been informed of a specific instruction to offer juice instead of water to Resident #22.Review of the facility's care plan policy revealed residents' comprehensive care plans are to include identified food and beverage preferences to ensure person-centered care and implementation by staff.

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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** Based on observation, medical record review, interviews and facility policy review, the facility failed to ensure residents who were dependent on staff were provided routine bathing. This affected two residents (#10 and #36) of six residents reviewed for activities of daily living (ADL). The facility census was 69. Findings Include: 1. Review of the medical record for Resident #10 revealed an initial admission date of 08/14/24 with the latest readmission date of 07/15/25. Diagnoses included but were not limited to spinal stenosis lumbar region, dementia, chronic obstructive pulmonary disease, palliative care, chronic respiratory failure, chronic pain, hyperlipidemia, hypertension, myasthenia gravis, diabetes mellitus, depression, anxiety, migraine, atrial fibrillation, congestive heart failure, cardiomyopathy, arthritis, candidiasis and anemia. Review of the resident's significant change MDS assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident had indicators of depression and displayed no behaviors, including rejection of care. Review of the plan of care dated 02/04/26 revealed the resident was receiving hospice benefits while residing in the facility due to end stage congestive heart failure (CHF). Interventions included give shower/bath, personal care, and nail care. Review of the resident's shower documentation for December 2025 revealed the resident had 14 opportunities for a scheduled shower. Further review revealed the facility had no documented evidence the resident received a shower and/or bed bath on 12/03/25, 12/08/25 and 12/31/25. Review of the resident's shower documentation for January 2026 revealed the resident had 13 opportunities for a scheduled shower. Further review revealed the facility had no documented evidence the resident received a shower and/or bed bath on 01/05/26, 01/07/26, 01/12/26, 01/16/26, 01/21/26 and 01/26/26. Review of the resident's shower documentation for February 2026 revealed the resident had 11 opportunities for a scheduled shower. Further review revealed the facility had no documented evidence the resident received a shower and/or bed bath on 02/02/26, 02/04/26, 02/11/26, 02/16/26 and 02/20/26. Review of the facility's shower schedule revealed the resident was to receive a shower or bed bath every Monday, Wednesday and Friday. On 02/23/26 at 10:12 A.M., observation and interview with Resident #10 revealed she had not had a bath in two weeks or had her hair combed in two weeks. Observation of the resident revealed the resident's hair had large areas of matted hair on the back of her head. Further observation revealed the resident's fingernails were long, jagged and had a brown substance under the nail. On 02/24/26 at 11:35 AM interview with Licensed Practical Nurse (LPN) #161 verified the resident had not received her scheduled showers or bed baths. On 02/26/26 at 9:44 A.M., an interview with Hospice Aide (HA) #201 revealed she provided a bed bath on 02/24/26 and washed the resident's hair. The HA revealed she worked most of the time removing the matted areas from her hair. The HA verified the resident's nails were long, jagged and had a brown substance under the nail. On 02/26/26 at 9:50 A.M., an interview with Certified Nursing Assistant (CNA) #113 revealed nail care was to be provided with showers and as needed. The CNA verified the resident's nails were long, jagged and had a brown substance under the nail. 2. Review of the medical record for Resident #36 revealed an initial admission date of 08/31/23 with the latest readmission of 10/10/23. Diagnoses included but were not limited to cerebrovascular accident with left sided hemiplegia, dysphagia, chronic congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, chronic kidney disease, hypertension, hyperlipidemia, schizophrenia, Alzheimer's disease, bipolar disorder, anxiety disorder, depression, insomnia, gastro esophageal reflux disease (GERD), anemia, constipation and atrial fibrillation. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior displayed no behaviors, including rejection of care. Review of the resident's shower documentation for December 2025 revealed the resident had 13 opportunities for showers. Further review revealed the facility had no documented evidence the resident received a scheduled (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower on 12/02/25, 12/06/25, 12/11/25 and 12/27/25. Review of the resident's shower documentation for January 2026 revealed the resident had 14 opportunities for showers. Further review revealed the facility had no documented evidence the resident received a scheduled shower on 01/03/26, 01/06/26, 01/15/26, 01/17/26, 01/22/26, 01/27/26 and 01/31/26. Review of the resident's shower documentation for February 2026 revealed the resident had 10 opportunities for showers. Further review revealed the facility had no documented evidence the resident received a scheduled shower on 02/07/26, 02/14/26 and 02/21/26. On 02/23/26 at 3:56 P.M., an interview with Resident #36 revealed she had not been provided a shower and/or bed bath in more than a week. Observation of the resident during the time of the interview revealed the resident's hair was unkempt and greasy. On 02/25/26 at 11:52 A.M., an interview with LPN #161 verified the resident had not received her scheduled shower and/or bed bath. Review of the facility policy titled, Shower-Tub Bath, last revised 05/01/25 revealed the facility would assist residents with bathing per their plan of care. Review of the facility policy titled, Nail Care Finger/Toe, last revised 05/01/25 revealed it was the policy of the facility to clean, trim and maintain nail care to enhance the resident's state of well-being.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure fall prevention interventions were implemented as indicated. This affected one resident (#47) of three residents reviewed for falls. The facility census was 69.Findings include:Review of the medical record for Resident #47 revealed an admission date of 12/08/18 with diagnoses including cerebral infarction, difficulty in walking, vascular dementia, muscle weakness, lack of coordination, other abnormalities of gait and mobility, and unsteadiness on feet.Review of the physicians orders revealed an order dated 03/10/25 to encourage resident to wear gripper socks when non-skid footwear not in place for safety three times a day and an order dated 01/18/26 or gripper sock on while out of bed.Review of the falls care plan last reviewed/revised 02/09/26 revealed Resident #47 was at risk for falls/injury related to incontinent of bowel/urine and impaired gait. Interventions included gripper socks applied for safety dated 07/08/25, encourage resident to wear gripper socks while in bed dated 01/24/21, and encourage resident to wear gripper socks when not wearing shoes dated 12/17/20.Observations on 02/23/26 at 3:29 P.M. revealed Resident #47 was observed without gripper socks on. 02/24/26 at 11:00 A.M., and 02/25/26 at 8:00 A.M. revealed Resident #47 was observed without gripper socks on. Observation and interview on 02/24/26 at 11:00 A.M. revealed Resident #47 was observed without gripper socks on and was attempting to stand up from the bed. Resident stated she is having a hard time due to the floor being slippery.Observation on 02/25/26 at 8:00 A.M. revealed Resident #47 was observed without gripper socks on.Interview with Registered Nurse (RN) #209 on 02/25/2026 at 2:14 P.M. it was verified Resident #47's gripper socks were not in place.Review of facility policy titled Fall Prevention, dated 05/01/25 revealed staff will ensure that safety interventions are in place for each resident to reduce the risk of falls.

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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** Based on medical record review, and staff interview, this facility failed to ensure a resident who required an indwelling foley catheter for bladder elimination was monitored for appropriate daily urine output as well as documenting urine output each shift. This affected one (Resident #46) of the three residents reviewed for bladder elimination. The facility census was 69.Findings include:Review of the medical record for Resident #46 revealed an admission date of 08/04/2023. Diagnoses included sepsis due to a urinary tract infection, acidosis, metabolic encephalopathy, and retention of urine. Review of Resident #46's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating a moderately impaired cognition for daily decision-making abilities. Resident #46 required an indwelling catheter for urine elimination. Review of the plan of care dated 07/29/2025 revealed Resident #46 had alteration in elimination related to obstructive uropathy and the need for a foley catheter. Interventions included to record intake and output as ordered by the physician. Review of the plan of care dated 07/31/2024 revealed Resident #46 had a potential for fluid imbalance and complications related to diagnosis including a history of urinary tract infection and acute kidney failure. Interventions included to observe for a fluid imbalance. Review of Resident #46's current physician orders revealed an order for staff to record urinary output three times a day. Review of Resident #46's urine output from 11/25/2025 through 02/24/2026 revealed urine output was not being documented three times a day and there were multiple days where it was documented only one time with some urine output for those days ranging between 100 to 200 milliliters for the entire day. Interview on 02/26/2026 at 1:30 P.M. with the Director of Nursing confirmed Resident #46 had a physician order for their urine output to be monitored and documented three times a day and this was not being completed per order.

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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** Based on record review, observation, and interview, the facility failed to ensure meal intakes were monitored and documented for three (Resident #44, #46, and #74), and the facility failed to ensure an order supplement was documented for one, (Resident #44). This affected three of six reviewed for nutrition and hydration. The facility census was 69. Findings include: 1.Review of the medical record for Resident #46 revealed an admission date of 08/04/2023. Diagnosis included sepsis due to a urinary tract infection, dysphagia oropharyngeal phase, and type two diabetes. Review of Resident #46's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 10 out of 15 indicating a moderately impaired cognition for daily decision-making abilities. Resident #46 was noted to be 68 inches tall and weight 199 pounds. Resident #46 required supervision for eating. Review of the plan of care dated 07/31/24 revealed Resident #46 was at risk for dehydration or fluid maintenance, potential for fluid imbalance and complications related to dysphagia, type two diabetes, and history of urinary tract infections. Interventions include to offer fluids at meals daily, observe for fluid imbalance, provide fluids at bedside between meals, monitor meal intakes. dietary to review meal intakes, and fluid needs. Review of Resident #46's current physician orders revealed a low concentrated sweet diet with thin consistency fluids and double portions at meals. There was also an order to encourage Resident #46 to drink eight ounce of water every shift. Review of Resident #46's meal intake including fluids from 11/25/2025 through 02/24/2026 revealed multiple days where only one to two meals were documented which included fluids for each meal. Some days reflected a fluid intake as low as 320 milliliters (ML). Interview on 02/26/2026 at 1:30 P.M. with the Director of Nursing confirmed Resident #46's meal intakes were supposed to be monitored and documented with each meal and confirmed there were not being properly monitored. Review of the facility policy titled Hydration, dated 05/01/2025 revealed: The goal for total fluid hydration offered per day should exceed 2300 ml, unless determined by the dietitian or medical provider that this volume of fluid is contraindicated due to the resident's medical condition. 2. Review of the medical record for Resident #74 revealed an initial admission date of 01/28/26 with diagnoses including muscle weakness, unspecified dementia, dysphagia, constipation, and major depressive disorder. Review of the plan of care last reviewed/revised 02/03/26 revealed the resident was at risk for altered nutrition regards to hypertensive emergency and past history of hypothyroidism, hyperlipidemia, hypertension and GERD (Gastro-esophageal reflux disease without esophagitis). Interventions included offer menu alternatives as needed, honor food preferences as available and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reasonable, provide diet per physician order and supplements per physician order. Review of the resident's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of the resident's meal percentage for January 2026 revealed no documented meal percentage intakes for 01/30/26 for breakfast and lunch. Review of the resident's meal percentages for February 2026 revealed no documented meal percentage intakes for 02/01/26 and 02/23/26 for breakfast, lunch and dinner; 02/03/26, 02/05/26, 02/06/26, 02/13/26, and 02/20/26 for breakfast and lunch; 02/04/26, 02/10/26, 02/14/26, 02/17/26, 02/19/26 for dinner. Review of nutrition progress note dated 02/03/26 at 10:03A.M. authored by Dietician #210 revealed intakes are good since admission, mostly 76-100% per medication administration record (MAR). No nutritional recommendations noted. Review of nutrition progress note dated 02/12/26 at 10:43 A.M. authored by Dietician #210 revealed family is requesting Boost supplement daily for additional nutritional support. Intakes are good, mostly 50-100%. Review of progress note dated 02/18/26 at 6:21 P.M. authored by Licensed Practical Nurse (LPN) #141 revealed resident with poor appetite and not eating meals. Interview on 02/25/26 at 11:00 A.M. with the Director of Nursing (DON), revealed aides are expected to do charting daily and the nurses are expected to check aides charting before the end of their shift. The DON verified the lack of documentation for meal intakes. Interview on 02/26/26 at 9:07 A.M. with Dietician #210 revealed the staff are entering supplements and meals most of the time. If she had any concerns, she sends an email to the DON and Assistant Director of Nursing (ADON) regarding missing meal percentages. She stated she needed the documentation of intakes in the residents record to do her job. 3. Review of the medical record for Resident #44 revealed an initial admission date of 08/20/23 with the latest readmission of 05/21/24 with the protein calorie malnutrition, Urinary Tract Infection (UTI), depression, mood disorder, hypothyroidism, anemia, metabolic encephalopathy, solitary pulmonary nodule, chronic pain, atrial fibrillation, anorexia, osteoarthritis, dementia, macular degeneration and cerebral atherosclerosis. Review of the plan of care dated 05/19/24 revealed the resident was at risk for altered nutrition with a recent history of significant weight loss. Interventions included offer menu alternatives as needed, honor food preferences as available and reasonable, provide diet per physician order and supplements per physician order. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident rejected care. The resident's weight was coded at 101 pounds, had no known weight loss and received a therapeutic diet. (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	02/26/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's meal percentage for December 2025 revealed no documented meal percentage intakes for 12/01/25, 12/03/25,12/04/25,12/05/25,12/06/25,12/07/25,12/09/25,12/10/25 12/15/25, 12/16/25,12/20/25, and 12/23/25 for breakfast and lunch, 12/13/25, 12/14/25,12/18/25,12/19/25,12/26/25, 12/29/25, 12/30/25 and 12/31/25 for dinner. Review of the resident's meal percentages for January 2025 revealed no documented meal percentage intakes for 01/01/25 for lunch and dinner, 01/02/25, 01/03/25, 01/04/25, 01/05/26, 01/06/26, 01/18/26, 01/21/26, 01/26/26, 01/27/26, 01/28/26 and 01/29/26 for breakfast and lunch, 01/07/26, 01/11/26, 01/12/26, 01/13/26, 01/14/26, 01/23/26, 01/24/26, 01/25/26 and 01/30/26 for dinner and 01/31/26 for lunch. Review of the resident's meal percentage for February 2026 revealed no documented meal percentage intakes for 02/01/26, 02/02/26 for dinner, 02/03/26, 02/04/26, 02/09/26, 02/10/26, 02/13/26 for breakfast and lunch, 02/06/26, 02/14/26, 02/15/26, 02/16/26, 02/17/26, 02/18/26, 02/21/26, 02/22/26, 02/23/26, 02/24/26 and 02/25/26 for dinner. On 2/26/26 at 8:34 A.M., an interview with the Director of Nursing (DON) verified the lack of documentation for meal intakes and each meal should be documented on the resident's electronic medical record.

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	02/26/2026

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility staff interview, and facility policy review, the facility failed to follow physician 's order for oxygen administration. This affected one resident (#9) of one resident reviewed for respiratory care. The facility census was 69.Findings include: Review of medical record for Resident #9 revealed an admission date of 12/13/23 and a readmission date of 11/17/25 with diagnoses including Parkinsons disease, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen. Review of the most recent Minimum Data Set (MDS) dated [DATE] revealed Resident #34 had a Brief Interview Mental Status (BIMS) score of 15 indicating no impaired cognition and she was receiving oxygen therapy. Review of the physician's orders dated 11/26/25 revealed oxygen two to four liters via nasal cannula to maintain saturations above 90 percent (%) every shift. Observation on 02/25/2026 at 10:11 A.M. of Resident #9 revealed the nasal cannula was in place and the oxygen concentrator was turned off. Interview and observation on 02/25/26 at 10:31 A.M. with RN #209 verified Resident #9's nasal cannula was in place but she was not receiving any oxygen due to the oxygen concentrator was not turned on. RN #209 further verified the physician's order for oxygen is continuous. Review of facility policy titled Oxygen Administration dated 05/01/25, revealed it is the facility's policy to provide oxygen services to residents using professional standards of care.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on medical record review and staff interview the facility failed to follow up with psychiatric recommendations in a timely manner. This affected one resident (#8) of two residents reviewed for mood and behavior. The facility census was 69.Findings include: Review of the medical record for Resident #8 revealed an admission date of 01/02/26 with diagnoses including schizophrenia, depression and muscle weakness. Review of the medical record revealed hospital clinical discharge instructions dated 01/02/26 with instructions to follow up with psychiatry in one week. Review of the hospital discharge documentation revealed Oxcarbazepine (an anticonvulsant medication sometimes used as a mood stabilizer) being down titrated to 30 milligrams (mg) and started on Lamotrigine (an anticonvulsant medication sometimes used as a mood stabilizer) 25 mg twice daily with slow up titration in outpatient setting. Review of Resident #8 ' s physicians orders revealed an order for Doxepin (antidepressant) 75 mg at bedtime, Invega Sustenna (antipsychotic) 156 mg/milliliters (ml) intramuscular injection every three weeks, Lamotrigine 25 mg twice daily, and Olanzapine (antipsychotic) 100mg twice daily. Interview on 02/25/26 at 2:00 P.M. with the Director of Nursing (DON) revealed the psychiatric nurse practitioner (NP) # 300 visited Resident #8 in house on 01/30/26 but it takes about a month to obtain the progress notes. If the NP had new orders, they are given to the DON or if the visit is on the weekend the orders are given to the floor nurses. DON stated the facility will obtain the NP # 300 progress note. Interview on 02/26/2026 8:15 A.M. with the DON provided the psychiatric progress note dated 01/30/26 and it revealed new recommendations to obtain Genesight testing if resident and family agreeable, obtain records from previous outpatient psychiatric provider to confirm diagnosis, previous medication trials, etc. The DON verified these recommendations were not completed.