

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365890	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Altercare Coshocton Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1991 Otsego Avenue Coshocton, OH 43812	
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 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. Based on medical record review, podiatrist note review, facility contract review, policy review, the American Association of Diabetes Standards of Diabetic Care 2025 and Cleveland Clinic web resource review, and facility staff and resident interviews the facility failed to ensure routine podiatry services and toenail trimming were provided to Resident #11 every one to three months as recommend by the American Diabetic Association Standards of Diabetic Care 2025 for individuals at high risk for development of diabetic ulcers. This affected one resident (#11) of three residents reviewed for activities of daily living. The facility census was 71. Findings include:Review of the medical record for Resident #11 revealed admission to facility on 07/21/24 with diagnoses including diabetes, diabetic peripheral angiopathy, gout, cellulitis right lower leg, diabetes, chronic lung disease, peripheral vascular disease (poor circulation from hardening or blockage of blood vessels in limbs including peripheral artery disease), heart disease, kidney disease, morbid obesity, heart failure, high blood pressure, and repeated falls.Review of the medical record for Resident #11 revealed several diabetic medications being prescribed for the management of her diabetes and blood sugar control. The medications for diabetes management included Actos (oral anti-diabetic pill) 15 mg, Trulicity (insulin) 1.5 mg, Lantus (insulin) 25 units. Further orders for management of diabetes included blood sugars monitoring four times a day and a lab test hemoglobin A1C (hga1c) to be obtained every 3 months to determine average blood sugar reading. Resident #11's most recent HgA1C obtained on 10/14/25 revealed a result of 7.8% putting Resident #11 at increased risk for complications of diabetes including infection.Review of the care plan for Resident #11 revealed on 08/01/24 an on-going care plan for diabetes was established to observe resident's feet for potential ulcer formation. An activity of daily living (ADL) care plan was established on 05/22/25 for Resident #11 to be provided with nail care and hair shampoo per weekly schedule. The care plan was non-specific for further assessment and monitoring of feet or nail care for Resident #11 who was at high risk for developing diabetic foot ulcers.Review of the medical record for Resident #11 revealed an on-going order written by primary care provider (PCP) #400 dated 07/22/24 to consult podiatry services as needed. Further review revealed Podiatrist #402 was consulted and visited Resident #11 in the facility for podiatry evaluation and treatments on 9/24/24, 12/07/24, 2/09/25, 02/11/25, 05/30/25. Review of Podiatrist #402 visit note completed and signed on 09/24/24 revealed Resident #11 was having difficulty ambulating. Nails were long, thick, discolored, layered and painful on both feet. Diagnosis included mycotic toenails and plan for periodic care needed to prevent pain and skin complications. Treated with debridement (clipping and cleaning) of nails to both feet.Review of Podiatrist #402 visit note completed and signed on 12/07/24 revealed Resident #11 was having difficulty ambulating. Nails were long, thick, discolored, layered and painful on both feet. Diagnosis included mycotic toenails and plan for periodic care needed to prevent pain and skin complications. Treated with debridement (clipping and cleaning) of nails to both feet.Review of Podiatrist #402 visit note completed and signed on 02/09/25 revealed Resident #11 having difficulty ambulating. Nails were long, thick, discolored, layered and painful on both feet. Diagnosis included mycotic toenails and plan for periodic care needed to prevent pain and skin complications. Treated with debridement (clipping and cleaning) of nails to both feet. Additional diagnosis included paronychia (infection of skin (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
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F 0687 Level of Harm - Actual harm Residents Affected - Few	around toenail) of second toe of right foot and Podiatrist #402 prescribed Cephalexin (oral antibiotic) 500 mg twice a day for seven days. Review of Podiatrist #402 visit note completed and signed on 02/11/25 revealed Resident #11 having difficulty ambulating. Nails were long, thick, discolored, layered and painful on both feet. Diagnosis included mycotic toenails and plan for periodic care needed to prevent pain and skin complications. Treated with debridement (clipping and cleaning) of nails to both feet. Podiatrist further noted that Resident #11 continued taking Cephalexin and second toe on right foot was improved. Review of Podiatrist #402 visit note completed and signed on 05/30/25 revealed Resident #11 was having difficulty ambulating. Nails were long, thick, discolored, layered and painful on both feet. Diagnosis included mycotic toenails and plan for periodic care needed to prevent pain and skin complications. Treated with debridement (clipping and cleaning) of nails to both feet. Review of Resident #11's medical record revealed no additional information related to the care provided to the resident's feet and toenails after 05/30/25. Review of nursing progress note dated 08/28/25 by Registered Nurse (RN) #149 for Resident #11 revealed warm, red left great toe and MD (medical doctor) notified. Further review revealed on 08/28/25 an in-person visit was made to Resident #11 by her primary care physician PCP #400 for acute visit related to an infected ingrown toenail to the left great toe. On 08/28/25 at 3:40 P.M. Resident #11 was prescribed an oral antibiotic cefdinir 300 milligrams (mg) twice a day for ten days by PCP #400. Review of the medication administration record revealed Resident #11 starting the medication on 08/29/25 and completed the entire 10-day course on 09/08/25. Continued review of nursing progress notes revealed on 09/08/25 RN #178 documented that Resident #11 complained of diarrhea and generalized weakness and the on-call nurse practitioner was notified and evaluated the resident. Resident #11's stool was tested and on 09/10/25 revealed positive for C-Diff (a contagious bacteria leading to severe diarrhea). On 09/10/25 Resident #11 was prescribed another oral antibiotic, Vancomycin 250 mg four times a day for 10 days and placed on isolation precautions by Nurse Practitioner (NP) #500. Resident #11 completed antibiotics on 09/20/25. Record review of nursing progress notes dated 09/30/25 by Licensed Practical Nurse (LPN) #148 revealed a new order was given by NP #500 to obtain stool test for C-Diff and contact isolation was put back in place. On 10/03/25 results of stool test revealed positive for C-Diff and NP #500 prescribed vancomycin (antibiotic medication) 125 mg four times a day for 10 days, then twice a day for 10 days, then daily for 10 days ending on 11/02/25. Review of the most recent quarterly Minimum Data Set 3.0 (MDS) assessment for Resident #11 dated 10/24/25 revealed a Brief Interview of Mental Status (BIMS) score of 15 out of 15, reflecting the resident was cognitively intact. Further review of the MDS revealed Resident #11 required supervision and touching assistance with nail care and grooming, supervision or light touching for transfers, use of motorized wheelchair for navigation throughout facility, substantial to maximal assistance to put on/take off footwear and dressing lower body and showering. Review of Podiatry Note by Podiatrist #403 completed and signed on 11/13/25 revealed Resident #11 had an initial evaluation completed, and nail clipping/debridement completed with recommendation to return in three months. Interview on 09/29/25 at 10:10 A.M. with Resident #11 revealed that she had an infected left great toenail and was treated with antibiotics for 10 days and developed C-diff diarrhea and was prescribed another 10 days of antibiotics. Resident #11 further reported she had started having diarrhea again yesterday (09/28/25). Further interview on 09/30/25 at 8:27 A.M. with Resident #11 revealed that her toes had been hurting, and she asked staff to cut her toenails and was told they were not allowed to cut toenails. Resident #11 stated the facility podiatrist, Podiatrist #402, wasn't coming to the facility anymore, so she hacked at them (her toenails) herself and that's how all the issues started. Interview on 12/01/25 at 1:25 P.M. with Resident #11 revealed confirmation that she was told in August 2025 that the nurses were not allowed to cut her toenails and the facility podiatrist was not available. Resident #11 reported she had not seen Podiatrist #402 since the end of May (2025). Resident #11 further reported that she finally did get an outpatient appointment scheduled and saw a new podiatrist outpatient on 11/13/25 and had her toenails cut and follow up appointment was (continued on next page)		

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F 0687 Level of Harm - Actual harm Residents Affected - Few	dates 9/24/24, 12/07/24, 2/09/25, 02/11/25, 05/30/25 in the electronic medical record. There was no podiatry visit noted for August, September, or October 2025 by Podiatrist #402. Review of the medical record of Resident #11 containing all discipline progress notes starting 08/01/25 in the electronic medical record revealed no communication by facility staff to the Podiatrist #402 from 08/01/25 to current 12/03/25. Review of an email sent by Regional Nurse #212 on 12/04/25 at 11:55 A.M. revealed an attachment containing a visit note dated 09/02/25 by Podiatrist #402 as a non-chargeable visit in which it stated the podiatrist evaluated Resident #11 but did not provide treatment and did not charge/bill Resident #11 for his services. There was no nail debridement noted. The note was not signed or dated by Podiatrist #402. Review of the facility policy titled Nail Care Finger/Toe updated on 05/01/25 revealed licensed nurses were permitted to trim toenails, nails of diabetic residents and residents with circulatory impairments. Residents with mycotic nails would require a physician to trim nails. Review of facility policy titled Ancillary Services dated 07/17 revealed the Social Services department would ensure any resident's need for any ancillary services were met to maintain a full continuum of medical care and services and would assist and/or oversee the process of referral. The policy further identified the social services coordinator and/or facility staff designee would schedule resident initial and routine ancillary services visits, as indicated. Review of American Diabetes Association's Diabetic Care, Standards of Care in Diabetes 2025 revealed, Individuals with any open ulceration or unexplained swelling, erythema (redness/irritation), or increased skin temperature should be referred urgently to a foot care specialist or interprofessional team, and Initial treatment recommendations should include daily foot inspection, use of moisturizers for dry, scaly skin, and avoidance of self-care of ingrown nails and calluses. Further review of American Diabetes Association's Diabetic Care, Standards of Care in Diabetes 2025 revealed the International Working Group on Diabetic Foot risk stratification system and corresponding foot screening frequency noting that persons with LOPS (loss of protective sensation) or PAD (peripheral artery disease) and renal disease or history of foot ulcer or deformity are moderate to high risk and should be examined every 1-3 months. Review of web-based resources by the Cleveland Clinic, Mycotic Nails: What Is It, Symptoms, Causes & Treatment (reviewed on 12/04/25), revealed mycotic nails can contribute to foot ulcers in diabetic individuals. Review of web-based resources by the Cleveland Clinic regarding HGA1C testing for diabetes revealed normal range for HGA1C to be less than 5.7%. HGA1C 5.7% to 6.4% indicates prediabetes and a result of 6.7% and above is significant for diabetes and as the number increases so does the risk of complications associated with diabetes such as infection or foot ulcers.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to properly store food products to prevent contamination. The facility also failed to maintain a clean, sanitary environment to prevent contamination of food prepared in the kitchen. This had the potential to affect 68 residents who consumed food from the kitchen. The facility census was 71. Findings include: On 09/29/25 at 8:45 A.M., in the kitchen, an observation of the area around the steam table and the stove top were covered in water, food substance and other white substances. This was confirmed by Dietary Coordinator (DC) #124 during the observation and tour of the kitchen. On 09/29/25 at 8:50 A.M., an observation of the kitchen area revealed a squeeze bottle with yellow liquid. The bottle was unlabeled and undated and sitting out on the metal preparation area table. On 09/29/25 at 8:55 A.M., DC #124 confirmed the yellow liquid in the bottle was butter and was unlabeled and undated. She reported this had been out on the preparation table since the night before. On 09/29/25 at 8:55 A.M., an observation of the racks of bread revealed a pack of Nickle's large sandwich buns. The buns had an outdate of 09/28/25. This was confirmed by DC #124 at the time of observation. On 09/25/29 at 8:59 A.M., an observation of the walk-in freezer revealed an open box of three ounce battered cod. The package inside the box was opened and unsealed. This was confirmed by DC #124 at the time of the observation. On 09/29/25 at 9:20 A.M. an observation of the reach in cooler revealed expired milk. There was a half pint of low fat chocolate milk with an expiration date of 09/28/25. This was confirmed by DC #124 at the time of the observation. On 09/29/25 at 9:20 A.M., an interview with DC #124 revealed all milk delivered by Avalon early in the morning of 09/29/25 was discovered to be either expired or smelled bad. DC #124 reported she noticed this and went and bought milk for the morning until new could be delivered. The two containers in the reach in cooler had been missed when she threw the rest out in the morning. No residents had been served expired milk. Review of a facility policy titled dating food, dated 08/12/20, revealed all food products received, stored, prepared and held in cooler, refrigerator, freezer or storeroom should be clearly labeled to indicate the received date, opened date, expiration date, and food item name. The policy further indicated open food items in the cooler/refrigerator and storeroom will be labeled with the opened date, expiration date, and the food item name. Open food items in the storeroom shall be sealed tightly in a container, baggie or plastic food grade container with a tight sealing lid, labeled with an open date, expiration date and the food item name. The Dating Food policy also indicated food items should be discarded on the manufacturer's use by date. This policy was confirmed by DC #124 on 09/29/25 at 11:59 A.M.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview the facility failed to prepare food by methods that conserve nutritive value, flavor, and appearance. This had the potential to affect four (#36, #68, #3, and #33) of four residents identified by the facility to be ordered pureed diets. The facility census was 71. Findings include: Review of the facility menu for 09/29/25 revealed pureed Citrus Glazed Turkey and Prince [NAME] Vegetables for the lunchtime meal. Dietary Coordinator (DC) #124 confirmed the menu, which she indicated was supplied to the facility, along with a recipe for each pureed item, by corporate. On 09/29/25 at 10:48 A.M., an observation and interview of [NAME] #113 revealed he was preparing pureed Prince [NAME] Vegetables for four residents. [NAME] #113 added four-4 ounce (oz) scoops of prepared Prince [NAME] Vegetables to the food processor, (four ounces of vegetables per resident serving). He then added two cups of hot water, and indicated the mixture was to be baby food consistency and should have one-half cup of hot water per serving. Next, he added four slices of wheat bread and indicated there was to be once slice of bread per serving of the vegetables. Review of a recipe titled Pureed Prince [NAME] Vegetables revealed a recipe for five servings of vegetables. The recipe included two and a half cups of prepared Prince [NAME] Vegetables (twenty ounces, which was the equivalent of four ounces per serving), two and a half slices of white bread (one half slice of white bread per serving), and two tablespoons of butter (0.4 tablespoons per serving). The cook was to place all ingredients into a sanitized food processor, and blend until smooth. Further, the recipe indicated if the mixture needed to be thinned, the cook should add an appropriate amount of a liquid (NOT WATER) to achieve a smooth pudding or soft mashed potato consistency. If the product needs thickened, add a commercial or natural food thickener (ex, potato flakes or baby rice cereal) to achieve a smooth, pudding or soft mashed potato consistency. Review of a recipe titled Pureed Citrus Glazed Turkey revealed a recipe for five servings of turkey. The recipe indicated one teaspoon of chicken base was to be mixed with one cup of water to make a broth. The cook should place one pound of prepared citrus glazed turkey and two and a half slices of white bread in a washed and sanitized food processor. It was to be blended until smooth. If the mixture needed thinned, the preparer was to add the mixed chicken broth until the mixture reached the correct consistency. If the mixture needed thickened, the preparer was to add natural food thickener, such as potato flakes or baby rice cereal to reach the correct consistency (smooth pudding or soft mashed potato consistency). On 09/29/25 at 10:53 A.M., an observation of the prepared pureed Prince [NAME] vegetables revealed the vegetables were very thin. The taste was of wheat bread and no vegetable flavor could be recognized. The Dietary Coordinator (DC) #124 and [NAME] #113 both sampled the mixture at the time of the observation and confirmed the mixture tasted of wheat bread and was very thin. To correct the issue at that time, cook #113 added three additional slices of wheat bread. On 09/29/25 at 11:00 A.M., an interview with DC #124 confirmed the recipe for pureed Prince [NAME] Vegetables, and further confirmed the recipe had not been followed. She confirmed there should not have been water added, and there was too much bread, as well as the wrong type of bread, in the mixture. She confirmed no margarine had been added to the puree. On 09/29/25 at 11:29 A.M., an interview with [NAME] #113, revealed he did not follow the recipe for citrus glazed turkey provided to the facility. He reported he used turkey and gravy to puree the turkey and confirmed this recipe was incorrect.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and was able to choose the option he or she preferred. This affected one (#10) of five residents reviewed for unnecessary medications. The facility census was 71. Findings include: Review of the medical record for Resident #10 revealed an admission date of 07/14/25. She was admitted with diagnoses which included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, chronic diastolic congestive heart failure, difficulty in walking, muscle weakness, unsteadiness on feet, dysphagia of oropharyngeal phase, obstructive and reflux uropathy, type two diabetes mellitus without complications, paroxysmal atrial fibrillation, secondary pulmonary arterial hypertension, major depressive disorder, single episode, hypotension, hyperlipidemia, hereditary and idiopathic neuropathy, gastro-esophageal reflux, morbid obesity, anxiety disorder, disorders of phosphorus metabolism, hypomagnesemia, hypokalemia, and personal history of malignant neoplasm of the breast. Review of a care plan for Resident #10, updated 8/12/25, revealed a problem area of psychotropic and antidepressant medications. There were interventions which included side effects of psychotropic and antidepressant medications, what to report, and non-pharmacological interventions to use prior to administration of medications. Review of the medical record for Resident #10 revealed medication orders for: lorazepam (ativan) for anxiety, dated 07/17/25; hydroxyzine (for anxiety) dated 07/23/25, and sertraline (antidepressant) dated 07/24/25. The record failed to reveal a consent for psychotropic medications on the dates these medications were initiated. This was confirmed by Registered Nurse (RN) #212 on 12/03/25 at 11:00 A.M. Interview with RN #212 revealed the facility did not have any psychoactive medication consents for Resident #10 prior to 08/10/25. There was an informed consent form, which included ativan, hydroxyzine, and sertraline, completed on 08/10/25, however this was noted to be after these medications were initiated. Review of an undated facility policy titled, Psychoactive Medication, revealed it was the policy of the facility to utilize psychoactive medication therapy to assist each resident to reach his/her highest practicable level of wellbeing. The policy indicated the medical record would contain documentation that the resident and responsible party had been made aware of the risks and benefits of these medications.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident financial record review, staff interview/email communication, and facility in-service documentation review, the facility failed to ensure all resident funds were placed in an interest-bearing account. This affected one (#44) of five residents reviewed for financial accounts. The census was 71. Findings include: Record review revealed Resident #44 was admitted to the facility on [DATE]. His diagnoses were dementia, schizoaffective disorder, dysphagia, drug induced akathisia, chronic obstructive pulmonary disease, edema, type II diabetes, pure hypercholesterolemia, bilateral primary osteoarthritis of knee, chronic kidney disease (stage III), cognitive communication deficit, muscle weakness, depression, paranoid personality disorder, bipolar disorder, hypertension, chronic respiratory failure with hypoxia, obesity, vitamin D deficiency, other specified anxiety disorders, schizophrenia, and anxiety disorder. Review of his minimum data set (MDS) assessment, dated 10/08/25, revealed he was cognitively intact. Review of Resident #44's interest-bearing funds account, dated August 2024 to December 2025, revealed the following facility AR refund were issued to this account: 09/17/24 (\$500), 12/11/24 (\$600), 03/04/25 (\$500), 04/09/25 (\$500), 06/24/25 (\$500), 07/09/25 (\$500), and 08/19/25 (\$1,000). Review of Resident #44's non-interest-bearing accounts receivable (AR) account, dated August 2024 to December 2025, reflected the same transactions and dates as listed above. The transactions on the AR account stated these refunds were listed as Cash Receipt RFMS transfer. Review of the transactions in this account found there was no interest accumulated for overages that were acquired by Resident #44. Interview with Regional Registered Nurse (RN) #212 on 12/01/25 at 1:45 P.M. confirmed Resident #44 had overages in his facility AR account, and when he needed money, that money would be transferred to his interest-bearing resident account at the direction of the guardian. She confirmed she would have the corporate financial staff speak with the surveyor to give specific information why there were overages in his facility AR account and the rationale of transferring it. Interview with Cash and Collections Supervisor #300 on 12/01/25 at 2:45 P.M. confirmed Resident #44 currently has overages/credits in his facility AR account, which came from a miscalculation by the state Medicaid office regarding his cost of care. She confirmed the money in his facility AR account is not interest-bearing, but when his guardian gave a directive to transfer money from the AR account to the interest-bearing resident account, they would do so. Email communication with Cash and Collections Supervisor #300 on 12/02/25 at 9:29 A.M. and confirmed the overages/refunds that were placed into his facility AR account, were a product of miscalculations/overages throughout the last four years. He current has an overage balance of \$730.58 in his facility AR account; but it will be transferred over to his interest-bearing resident account when the guardian gives them the directive. Review of facility Resident Fund Management System (RFMS) training guidelines, undated, revealed a Medicaid resident (which Resident #44 was), will have a \$50 monthly allowance at minimum. Their training does not reflect any information about the resident personal funds needing to be in an interest-bearing account if the total is above \$50.		

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NAME OF PROVIDER OR SUPPLIER Altercare Coshocton Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1991 Otsego Avenue Coshocton, OH 43812	
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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident financial record review, staff interview/email communication, and facility in-service documentation review, the facility failed to ensure all resident funds were not co-mingled in other facility accounts. This affected one (#44) of five residents reviewed for financial accounts. The census was 71. Findings Include:Record review revealed Resident #44 was admitted to the facility on [DATE]. His diagnoses were dementia, schizoaffective disorder, dysphagia, drug induced akathisia, chronic obstructive pulmonary disease, edema, type II diabetes, pure hypercholesterolemia, bilateral primary osteoarthritis of knee, chronic kidney disease (stage III), cognitive communication deficit, muscle weakness, depression, paranoid personality disorder, bipolar disorder, hypertension, chronic respiratory failure with hypoxia, obesity, vitamin D deficiency, other specified anxiety disorders, schizophrenia, and anxiety disorder. Review of his minimum data set (MDS) assessment, dated 10/08/25, revealed he was cognitively intact. Review of Resident #44's interest-bearing funds account, dated 12/01/25, revealed he had a total of \$0.58 in his personal spending/needs account. Review of Resident #44's non-interest-bearing accounts receivable (AR) account, dated December 2025, revealed he had an overage total of \$730.58. Interview with Regional Registered Nurse (RN) #212 on 12/01/25 at 1:45 P.M. and Cash and Collections Supervisor #300 on 12/01/25 at 2:45 P.M. confirmed Resident #44 has personal money in both his interest-bearing resident account and his facility AR account. When asked why he had money in both accounts, Cash and Collections Supervisor #300 stated they keep money in that account just in case his patient liability and cost of care changes, so Resident #44 wouldn't owe them money. She also confirmed they would move money from the AR account to the interest-bearing resident account at the direction of Resident #44 guardian, because he would spend all his money if it was all in his resident account. Review of facility Resident Fund Management System (RFMS) training guidelines, undated, revealed their training does not reflect any information about the resident's money not being co-mingled between multiple accounts.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) review, policy review and interview, the facility failed to ensure residents were offered and documented their decision in regards to continuation of skilled therapy services and their inpatient stay at the facility as required. This affected two residents (#53, #60) of three residents sampled. The census was 71. Findings include:1. Medical record review revealed Resident #60 was admitted on [DATE] with diagnoses including congestive heart failure, muscle weakness and difficulty walking.Review of the SNF ABN dated 08/11/25 revealed Resident #60's inpatient skilled facility services including their inpatient stay at the facility would no longer be covered as of 08/14/25. The SNF ABN identified three options for the resident to chose including to continue receiving services and bill Medicare, continue to receive services without billing Medicare, or do not continue the skilled care. The SNF ABN indicated to check only one of the three boxes; however, Resident #60 did not indicate which option was chosen.2. Medical record review revealed Resident #53 was admitted on [DATE] with diagnoses including muscle weakness, metabolic encephalopathy, congestive heart failure and myocardial infarction. Review of the SNF ABN dated 05/06/25 revealed Resident #53's Medicare Part A skilled services last covered day was on 05/06/25. The SNF ABN indicated to check only one of the three options and none were marked. Documentation at the bottom of the form indicated on 05/01/25 at 10:00 A.M. Admissions Coordinator #201 verbally notified the Resident #53's power of attorney (POA) via phone of the non-coverage, their appeal rights were explained and the POA was made aware of the ending skilled service date of 05/06/25 which included a financial liability to begin on 05/07/25. No option was chosen to indicate the POA's decision. The facility did not have a policy for review regarding completion of the SNF ABN at the time of the survey. On 12/02/25 at 12:47 P.M., interview with Social Services #211 verified the above SNF ABN's did not indicate the option chosen by Resident #53 or Resident #60.On 12/02/25 at 1:05 P.M., interview with Admissions Coordinator #201 verified there were no decisions marked on Resident #53 or #60's beneficiary notices indicating the resident/POA decisions regarding the discontinuation of skilled services as required. Admissions Coordinator #201 stated she reviewed the forms with the POA over the phone but did not document the choice made. Admissions Coordinator #201 stated she sent the SNF ABN via certified mail to the POA and had been waiting for the signed forms back but to date had not received them.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to maintain a clean and sanitary environment. This affected one resident (#22) of three residents observed for skin treatments. The census was 71. Findings include: Medical record review revealed Resident #22 was admitted on [DATE] with diagnoses including cerebral palsy, pyoderma (bacterial skin infection), and methicillin resistant staphylococcus aureus infection of the scalp. Review of the Dermatology Physician Assistant Progress Note dated 08/21/25 revealed treatment orders for Resident #22's pyoderma included to apply a thick layer of gentamicin 0.1 % ointment to the red areas on her scalp and inside her nose twice a day until healed. On 09/29/25 at 11:53 A.M., observation revealed Resident #22's privacy curtain and wall next to the bed had a dried brown substance smeared on both surfaces. On 09/30/25 between 9:00 A.M. and 9:13 A.M., observation revealed Resident #22 was laying in bed. The resident's privacy curtain, pillow and wall next to her bed was observed to have brown staining and smears of blood on the surfaces. The resident's scalp had scattered open areas that were observed to be bleeding. On 09/30/25 at 9:20 A.M. observation with Registered Nurse #216 verified the above and stated the brown staining/substance on the wall, pillow case and privacy curtain was probably dried blood but was not completely sure.		

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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, observation and interview, the facility failed to review baseline care plans with newly admitted residents within the required timeframe. This affected one resident (#81) of four newly admitted residents sampled. The census was 71. Findings include: Medical record review revealed Resident #81 was admitted on [DATE] with diagnoses including left hip replacement revision and diabetes mellitus. Review of the admission Nursing assessment dated [DATE] revealed an unsigned Baseline Care Plan dated 09/27/25. There was no evidence the resident was provided the baseline care plan or that it had been reviewed with him. Review of the Clinical admission Documentation assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making. The document indicated the facility was to obtain a resident signature and date confirming the baseline care plan was provided to them. Review of the record revealed no evidence this was completed. On 09/29/25 at 10:10 A.M., interview with Resident #81 stated no facility staff had come to speak with him, discussed his plan of care with him or provided a copy of his baseline care plan since admission. On 09/30/25 at 8:41 A.M., observation revealed Social Service Coordinator #167 entered Resident #81's room and left the door open. Sitting across the hallway, SSC #167 was heard asking the resident questions regarding his code status, PTSD questions, needs at home, therapy, discharge plans and paperwork. Upon exiting the room, interview with SSC #167 verified the above and was unable to provide a signed copy of the baseline care plan. On 12/02/25 at 4:56 P.M., interview with Registered Nurse #212 verified Resident #81 had not been provided a copy or explained the baseline care plan during the required time frame.		

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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, policy review and interview, the facility failed to provide nail care to a dependent resident. This affected one resident (#22) of three residents sampled for activities of daily living (ADL). The census was 71. Findings include: Medical record review revealed Resident #22 was admitted on [DATE] with diagnoses including cerebral palsy, schizoaffective disorder, pyoderma and cerebral vascular accident. Review of the electronic Profile Sheet dated 01/17/25 revealed the resident was dependent on staff for nail care. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making, had functional impairment of the upper and lower extremities and was dependent on staff for personal hygiene which included nail care. Review of the care plan: ADL (activities of daily living) Functional Status/Rehabilitation Potential revised 08/15/25 revealed impaired ability to perform ADL's due to weakness and cerebral palsy. Interventions included to provide nail care per weekly schedule. Review of Resident #22's Shower Sheets revealed the resident received a shower on 09/29/25. There was no evidence nail care was provided. On 09/29/25 at 9:49 A.M., observation revealed Resident #22's fingernails on her left hand were jagged and unclean. The resident's fingers on the right hand were not able to be observed due to her fingers were tightly pressed into the palm of her hand. On 09/30/25 at 9:00 A.M., observation revealed Resident #22's fingernails on her left hand were jagged and unclean. On 09/30/25 at 9:13 A.M. interview with Registered Nurse #213 verified Resident #22's left hand fingernails were jagged and unclean. On 09/30/25 at 9:22 A.M., observation revealed Certified Nurse Assistant (CNA) #214 was observed entering Resident #22's room. CNA #214 stated Resident #22 was dependent on staff for ADL care and verified she was providing nail care due to the resident's nails were jagged. Review of the policy: Nail Care Finger/Toe revised 05/01/25 revealed the facility was to clean, trim and maintain resident nails. Nail care included daily cleaning and regular trimming.		

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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** Based on medical record review, policy review and interview, the facility failed to provide adequate care and services related to the treatment of constipation, preventative measures for urinary tract infections, and post-operative treatment of hip surgery. This affected two residents (#22, #81) of seven residents reviewed for quality of care and treatment. The facility census was 71. Findings include:1. Medical record review revealed Resident #22 was admitted on [DATE] with diagnoses including cerebral palsy, schizoaffective disorder and chronic idiopathic constipation. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #22 was cognitively intact for daily decision-making, was always incontinent of bowel, dependent on staff for toileting, and was receiving antibiotics and opioid medications. a. Review of Resident #22's Bowel Records revealed no evidence of a bowel movement (BM) between 07/31/25, 08/01/25, 08/02/25, 08/03/25 and 08/04/25. Review of the Bowel Records dated 09/10/25, 09/11/25, 09/12/25 and 09/13/25 also revealed no evidence of a BM. Review of the electronic Medication Administration Record (eMAR) dated July 2025 and August 2025 revealed Resident #22 received tramadol (opioid) 50 milligrams (mg) twice a day. The resident had as needed (PRN) medications including Senna (laxative) 8.6 milligrams and milk of magnesium (MOM) 400mg/5mL give 30 cc for constipation. Review of the August 2025 eMAR revealed no evidence Senna or MOM was administered to treat Resident #22's constipation between 07/31/25 and 08/04/25. Review of the eMAR dated September 2025 revealed Resident #22 continued to receive tramadol 50 (mg) twice a day. Review of the Urogynecology Consult After Visit Summary dated 09/11/25 revealed the physician discontinued Senna 8.6 milligrams (mg) every 24 hours PRN and ordered the resident to receive Fibercon 625 (mg) and Miralax (laxative) 17 grams twice a day. Both new orders were scheduled and initiated on 09/12/25. The physician was not notified the resident had not had a BM between 09/10/25, 09/11/25, 09/12/25 and 09/13/25 and the residents constipation was not addressed. The resident had a BM on 09/14/25. Review of the care plan: Potential for Constipation related to decreased mobility and medications dated 09/12/25 revealed Resident #22's goals included to have a soft formed bowel movement at least every three days. Interventions included document bowel movements and administer medications as ordered. Review of the care plan: Potential for Incontinence of Bowel and At Risk for Altered Dignity, Skin Breakdown, Diarrhea and Constipation revised 08/13/25 revealed goals to have a soft BM at least every three days without any complications. Interventions included to administer medications per physician order. On 09/30/25 at 4:14 P.M., interview with Registered Nurse (RN) #212 verified Resident #22 did not receive interventions or medications as ordered to treat the resident's constipation. b. Review of the Urogynecology Consult After Visit Summary dated 09/11/25 revealed Resident #22 was ordered to start medications to prevent urinary tract infections including cranberry tablets 500 (mg) twice a day and D-Mannose 1000 (mg) twice a day with physician instructions to take two hours apart from the cranberry tablet. Review of the eMAR dated September 2025, October 2025, November 2025 and December 2025 revealed Resident #22 was receiving cranberry tablet 450 (mg) once a day and D-Mannose 1000 mg twice a day. Both medications were administered within the same timeframe. On 12/02/25 at 4:56 P.M., interview with RN #212 verified Resident #22 was not receiving the correct dose of cranberry or the ordered frequency, and the physician instructions to administer D-Mannose and cranberry two hours apart was not transcribed to the order or implemented. 2. Medical record review revealed Resident #81 was admitted on [DATE] with diagnoses including a left hip joint replacement revision. Review of the hospital Discharge summary dated [DATE] revealed Resident #81 was ordered to receive medications including cefadroxil (antibiotic), etodolac (non-steroidal anti-inflammatory), lisinopril-HCTZ (hypertension), meloxicam (NSAID), pravastatin (cholesterol) and xarelto (anticoagulant). Review of Resident #81's electronic Physician Orders and eMAR dated September 2025 revealed cefadroxil 500 (mg) twice a day, etodolac (continued on next page)		

Department of Health & Human Services
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	400 (mg) twice a day, lisinopril-hydrochlorothiazide 20 mg/12.5 mg daily, meloxicam 7.5 (mg) twice a day, pravastatin 20 (mg) daily, and xarelto 10 (mg) daily were not started until 09/29/25 due to the medications were unavailable to be administered. Review of the pharmacy Packing Slip dated 09/28/25 revealed Resident #81's medications ordered at the time of admission on [DATE] were delivered to the facility on [DATE]. On 12/02/25 at 4:50 P.M., interview with RN #212 verified Resident #81's medications were not available to be administered on 09/27/25 or 09/28/25 due to the medications had not been delivered from the pharmacy. RN #212 verified this was not considered timely and did not know why the medications were not delivered over the weekend. Review of the policy: IIA2: Medication Administration-General Guidelines revised May 2020 revealed medications were to be administered in accordance with orders of the prescriber.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and review of facility policy, the facility failed to implement an adequate and effective pressure ulcer prevention program to prevent the development of pressure ulcers. This affected one (#83) of three residents reviewed for pressure ulcers. The facility census was 71. Findings include: Review of the medical record for Resident #83 revealed an admission date of 10/30/25 with diagnoses including metabolic encephalopathy, chronic respiratory failure with hypoxia, and chronic obstruction pulmonary disease (COPD). Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 10. The resident was assessed to require dependent on staff for toileting, showering/bathing, and transfers, and substantial/maximal assistance with turning and repositioning. Review of Resident #83's care plan dated 11/14/25 revealed Resident #83 had a pressure injury to left buttock and was at risk for skin breakdown related to impaired mobility, edema, urinary incontinence, bowel incontinence, COPD, lung cancer, renal disease, poor sensory perception, friction concerns and shearing concerns. Interventions included pressure re-distribution cushion to wheelchair, assist resident as needed with turning and positioning frequently when in bed and/or shift weight to reposition when in chair as tolerated, encourage resident not to slide/scoot when in bed/chair, observe resident for any incontinence episodes and provide incontinent care as needed, apply protective barrier after each incontinent episode, observe for any noncompliance with preventative skin care and notify physician as needed, observe/report any signs and symptoms of skin irritation and provide nutritional support as ordered. Subsequent review of the medical record revealed an initial wound grid documentation dated 12/02/25, indicated Resident #83 was found with a new Stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) to the right buttock measuring 1.5 centimeters (cm) long by 2.0 cm wide by 0.1cm deep. Review of Resident #83's physician orders dated 11/13/25 revealed an order for Triad wound dressing (OTC) over the counter, apply a thin layer to the left buttock wound every shift and as needed. A physician's order dated 12/02/25 revealed an order for Triad wound dressing (OTC) over the counter, apply a thin layer to the right buttock wound every shift and as needed. Physician's orders revealed an order for Prosource No carb liquid 30 milliliters (mL), twice daily dated 11/18/25 and on 12/02/25 an order for sugar free house supplement 4 ounces daily was ordered. Observations throughout the survey on 12/02/25 at 11:00 A.M., 1:30 P.M., 3:15 P.M., and 4:00 P.M. and on 12/03/25 at 8:00 A.M. and 10:00 A.M. revealed Resident #83 positioned on his back in bed. Interview on 12/02/25 at 3:24 P.M. with RN #151 revealed she measures wounds on Mondays and Thursdays. The wound physician comes in weekly on Thursdays. Resident #83 returned from the hospital with the pressure ulcer to his left buttock and the right buttock wound was in house acquired. He has pressure relieving cushion to wheelchair, protein supplement, and standard turning and repositioning every 2 hours. A new intervention was added for house supplement for the new pressure ulcer. RN#151 verified Resident #83 has not been evaluated by the wound physician and no other interventions were in place for Resident #83 for prevention of pressure ulcers. Review of facility policy titled Pressure Injuries: Assessment, Prevention, and Treatment dated 05/01/25 revealed, it is the facility's policy to identify residents at risk for developing pressure injuries, implement interventions to prevent the development of pressure injuries and provide care for existing pressure injuries. This deficiency represents non-compliance investigated under Complaint Number 2667472.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on record review, observation and interview, the facility failed to provide oxygen to a resident at the flow rate ordered by the physician. This affected one (#10) of three residents reviewed for respiratory concerns. The facility census was 71. Findings include: Review of the medical record for Resident #10 revealed an admission date of 07/14/25. She was admitted with diagnoses which included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, chronic diastolic congestive heart failure, difficulty in walking, muscle weakness, unsteadiness on feet, dysphagia of oropharyngeal phase, obstructive and reflux uropathy, type two diabetes mellitus without complications, paroxysmal atrial fibrillation, secondary pulmonary arterial hypertension, major depressive disorder, single episode, hypotension, hyperlipidemia, hereditary and idiopathic neuropathy, gastro-esophageal reflux, morbid obesity, anxiety disorder, disorders of phosphorus metabolism, hypomagnesemia, hypokalemia, and personal history of malignant neoplasm of the breast. Review of the medical record for Resident #10 revealed an order for oxygen. The order was dated 08/05/25 and read, Continuous oxygen at 4 liters per nasal cannula. Check placement every shift. On 09/30/25 at 10:28 A.M., an observation of Resident #10 revealed the resident was wearing oxygen by nasal cannula. The oxygen concentrator was set to a flow rate five Liters (L). This was confirmed by Licensed Practical Nurse (LPN) #137 at the time of observation. On 09/30/25 at 10:40 A.M., LPN #137 confirmed the order for Resident #10's oxygen. She reported the oxygen flow rate should be four liters by nasal cannula, not five liters.		

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and facility policy review, the facility failed to have a proper parameters for as needed pain medication. Also, the facility failed to acquire pain medication in a timely manner for a resident who had documented pain. This affected two (#1, #81) of three residents reviewed for pain management. The census was 71. Findings include: 1. Record review revealed Resident #1 was admitted to the facility on [DATE]. His diagnoses were chronic respiratory failure, chronic obstructive pulmonary disease, pneumonitis, anemia, congestive heart failure, encephalopathy, difficulty walking, muscle weakness, cognitive communication deficit, pleural effusion, hypertension, dementia, hyperlipidemia, peripheral vascular disease, visual hallucinations, anxiety disorder, major depressive disorder, and pneumonia. Review of his minimum data set (MDS) assessment, dated 08/01/25, revealed he was cognitively intact. Review of Resident #1's physician orders revealed he had the following as needed pain medications ordered: acetaminophen 325 milligrams (mg) two tabs every four hours as needed for pain rated one to ten, which was ordered on 07/29/25; and oxycodone five mg every four hours as needed for pain rated one to ten, which was ordered on 07/30/25. Review of Resident #1's medication administration records, dated September 2025 to December 2025, revealed the following doses of pain medication administered with corresponding pain levels at the time the medication was administered: August 2025, as needed acetaminophen was not administered, but as needed oxycodone was administered two times; one for pain level three and one for pain level eight. November 2025, as needed acetaminophen was administered one time for pain level ten, and acetaminophen was administered nine times with the pain levels rating between five and ten. Interview with Regional Registered Nurse (RRN) #192 on 09/30/25 at 9:48 A.M. revealed pain medications are offered and given as ordered. For as needed pain medications, RRN #192 confirmed there are usually parameters as to when to give each as needed pain medication. RRN #192 also confirmed that they will administer a stronger medication (oxycodone) when the pain level is higher, such as pain level six or higher. RRN #192 confirmed the administration doses given for Resident #1 and confirmed there were the same pain parameters for both pain medications. Review of facility Pain Medication Administration policy, dated 05/01/25, revealed it is the facility's policy to administer pain medications in accordance with professional standards of practice. Administer as needed pain medication as ordered. If multiple pain medications or dosages are ordered, all the resident to choose pain medication to be administered. 2. Medical record review revealed Resident #81 was admitted on [DATE] with diagnoses including a left hip joint replacement revision and diabetes mellitus. Review of the hospital Discharge summary dated [DATE] revealed Resident #81 was ordered to receive medications including: meloxicam (non-steroidal anti-inflammatory) 7.5 milligrams (mg) every 12 hours, oxycodone Immediate Release (opioid) 5 (mg) every six hours as needed (PRN) for severe pain, and tramadol (opioid) 50 (mg) one to two tablets every six hours PRN for moderate pain. Review of the admission Clinical Nursing assessment dated [DATE] revealed Resident #81 was cognitively intact for daily decision-making. Review of the unsigned Baseline Care Plan dated 09/27/25 revealed Potential for Alteration in Pain with interventions to encourage the resident to (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Altercare Coshocton Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1991 Otsego Avenue Coshocton, OH 43812	
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report any pain, note pain by using indicators of pain intensity, location, medicate for pain as ordered, and to report complaints of pain to the physician if not receiving pain medication. Review of the eMAR dated September 2025 revealed oxycodone 5 (mg) PRN and tramadol 50 (mg) PRN were not administered on 09/27/25 or 09/28/25. On 09/28/25, the eMAR indicated Resident #81 complained of pain rating it as a five out of 10 on the night shift. There was no evidence of a comprehensive assessment or interventions implemented to address the resident's pain. Review of the pharmacy Controlled Drug Receipt/Proof-Of-Use/Disposition Form labeled oxycodone IR 5 (mg) and Tramadol 50 (mg) revealed the order was received at the pharmacy on 09/28/25 and the medication was delivered to the facility on [DATE]. There was also no evidence pain medication was administered from the emergency medication supply for the resident. On 09/29/25 at 10:10 A.M., interview with Resident #81 stated he did not receive timely pain management for complaints of pain over the weekend. On 12/02/25 at 4:50 P.M., interview with Registered Nurse (RN) #212 verified oxycodone IR and tramadol were not available to be administered at the facility until 09/29/25. RN #212 stated she looked at the starter/emergency medication supply and no doses had been removed for Resident #81. RN #212 verified Resident #81's pain rated a five out of 10 on 09/28/25 was not addressed.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure a resident's medical record was complete and accurate to reflect an advanced level provider (nurse practitioner) was notified and an order was received for a resident to be released from the facility AMA (against medical advice) and accuracy of treatment recommendations for medications. This affected two (#22, #74) of nine residents reviewed for accuracy of medical records. Findings include: 1. Review of Resident #74's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included osteomyelitis of the vertebra (lumbar region), sepsis of an unspecified organism, congestive heart failure, anxiety disorder, and major depressive disorder. Review of Resident #74's physician's orders revealed he was admitted to the facility with orders to receive intravenous (IV) antibiotics to include Ceftriaxone 2 grams once daily and Vancomycin 1.5 grams twice a day. His physician's orders also included treatment orders for a peripherally inserted central catheter (PICC) line that was being used as his IV access for the antibiotics. Review of Resident #74's progress notes revealed a nurse's note dated 07/03/25 at 4:31 P.M. that indicated the resident was admitted to the facility via family transport. He was alert and oriented to person, place, time, and situation. He was able to answer questions asked appropriately and had a PICC line to his right upper extremity with a dressing intact. Further review of Resident #74's progress notes revealed a nurse's note dated 07/03/25 at 9:38 P.M. that indicated Resident #74 called a family member to pick him up. The note indicated the resident signed an AMA form and took all his possessions with him. The progress notes did not provide any documented evidence of the physician or another advanced level provider being notified of him leaving the facility AMA. There was not any other progress notes other than the initial admission note and the nurse's note that indicated he had called his family and left the facility AMA. Further review of Resident #74's physician's orders revealed there was not an order written for the resident to be released from the facility AMA. The only orders included in the electronic medical record (EMR) were the orders that were present upon his admission. Review of an Informed Consent and Release of Responsibility for Discharging Self Against Medical Advice form revealed Resident #74 was transferred from the hospital after undergoing treatment for post-surgery. The form indicated he signed himself out AMA on 07/03/25. No time was indicated on the form. The nurse that documented the resident leaving AMA in the nurse's note on 07/03/25 at 9:38 P.M. signed the AMA form as well. The informed consent and release of responsibility for discharging self against medical advice was a generic form and not specific to the resident's risks associated with him leaving AMA. There was nothing included on the form the resident signed that addressed him leaving the facility with a PICC line. On 12/02/25 at 2:10 P.M., an interview with the facility's Director of Nursing (DON) and Regional RN #212 revealed the facility's current DON was not the DON when Resident #74 left the facility AMA. They identified the nurse who was working when Resident #74 left the facility AMA as an agency nurse and not one of the facility's employees. They were asked to provide the contact number for the agency nurse, but no phone number was provided. They acknowledged the medical record did not provide any documented evidence of the resident's physician or another advanced level provider being (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified of the resident leaving the facility AMA. They further acknowledged the medical record also lacked a physician's order for the resident to be released from the facility AMA. Regional RN #212 stated she would have to look into the matter to determine what all had transpired when the resident left AMA on 07/03/25 and why the resident's medical record lacked evidence of physician notification and an order to release the resident from the facility AMA. On 12/03/25 at 9:30 A.M., an interview with Regional RN #212 revealed she had looked into Resident #74 leaving the facility AMA and determined the incident involving the resident leaving AMA had been witnessed by one of the facility's night shift nurses (LPN #157). She talked to that nurse and was able to determine the nurse witnessed Resident #74 leaving the facility after calling his wife to come get him. The agency nurse on duty at the time had the resident sign an AMA form as he was walking out the door. She denied the facility staff had any prior knowledge of the resident wanting to leave or that he had contacted his wife to come get him. It was previously planned (prior to his admission into the facility) that he would just go straight home from the hospital, where his wife would give him his IV antibiotics. They then decided the resident would come to the nursing facility to receive his IV antibiotics. The resident later decided, after he was admitted, that he did not want to be there and called his wife to come and get him. She reported the nurse practitioner that visited the facility was notified of the resident leaving AMA. She provided the phone number of the facility's nurse (LPN #157) that allegedly witnessed the resident signing himself out AMA, as well as the nurse practitioner who was notified of the resident leaving AMA. She acknowledged the resident's medical record did not show documented evidence of the nurse practitioner being notified, nor did it include an order to discharge the resident from the facility AMA. She claimed the resident had a follow up appointment scheduled with the Infectious Disease Clinic on 07/07/25 and already had all the IV antibiotics/ supplies he needed at home, since it was his original plan to go home directly from the hospital. On 12/03/25 at 9:35 A.M., a call was placed to LPN #157 to verify the events that took place with Resident #74 leaving the facility AMA, as was reported by Regional RN #212. A message was left on her voicemail, but no return call was received. On 12/03/25 at 9:38 A.M., a call was placed to Nurse Practitioner #500 at a number provided by the facility. No answer was received, but a message was left on her voicemail to return the call at her earliest convenience. A return call was received on 12/03/25 at 9:45 A.M. She confirmed she had been made aware of Resident #74 leaving the facility AMA. She was informed he wanted to leave and the wife had everything he needed at home to continue with his care. She believed she was notified after the resident had already left, but was told sometime that same evening. She recalled the resident had all his belongings packed up and was ready to leave when the wife came in to get him. They considered his discharge to be AMA, as the resident did not provide them any prior notice that he was wanting to leave and they had not had the opportunity to do proper discharge planning with setting up home health services. She did not have any concerns with how the facility handled the situation, as the resident already made up his mind he was leaving, and did not inform the facility of his plans until the wife showed up to take him home. A review of the facility's policy on Discharge Against Medical Advice updated 05/01/25 revealed the facility recognized that every competent adult or legally authorized person had the right to make informed decisions regarding the resident's medical care. The procedure indicated when a resident or legally authorized person requested that he/ she be discharged from the facility, the primary care physician would be notified. If the primary care physician was not in agreement with the resident's or the legally authorized persons request to be discharged, due to health and safety concerns for the resident, the physician would provide an order for the resident to be discharged against medical (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	advice. The resident and/ or the resident representative would be notified that the physician was not in agreement with their decision and the discharge would be against medical advice. A licensed nurse would then review with the resident and/ or their representative the risks and benefits of their decision to leave against medical advice. The licensed nurse would present an informed consent document that explained the risk of discharging against medical advice. The resident and or the resident representative would sign and date the document that they have been educated on the risks of discharging against medical advice. The resident and/ or the resident representative would be offered a copy of their physician's order. 2. Review of the medical record revealed Resident #22 was admitted on [DATE] with diagnoses including cerebral palsy, schizoaffective disorder, generalized anxiety disorder and major depression disorder. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #22 was cognitively intact for daily decision-making and received antipsychotic, antianxiety and antidepressant medications. Review of the Psychiatric Progress Note dated 08/01/25 revealed treatment recommendations included to continue clonazepam (benzodiazepine) 0.5 mg by mouth three times daily PRN (as needed) and to continue Trazodone (antidepressant) 25 (mg) by mouth every evening. Effectiveness and side effects of the medications were to be monitored. Review of the Physician Orders and Medication Administration Record dated August 2025 revealed no evidence Resident #22 received clonazepam 0.5 (mg) three times a day PRN, and trazodone was ordered to be administered at 50 (mg) every evening not 25 (mg). On 09/30/25 at 4:10 P.M., interview with Registered Nurse #212 verified the Psychiatric Progress Note was inaccurate and the treatment recommendations were not intended for Resident #22 as indicated above.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review and interview, the facility failed to maintain adequate infection control practices during a skin treatment. This affected one resident (#22) of two residents observed for wound treatments. The census was 71. Findings include: Medical record review revealed Resident #22 was admitted on [DATE] with diagnoses including cerebral palsy, schizoaffective disorder, pyoderma and cerebral vascular accident. Review of the care plan: Requires Enhanced Barrier Precautions (EBP) related to uncontrolled secretions or excretions dated 07/22/24 revealed to utilize the use of personal protective equipment of gowns and gloves during high contact resident care activities when in room, shower room or in therapy. Staff to perform frequent hand hygiene before and after patient contact/care and EBP supplies were to be placed in the resident's room. Review of the Dermatology Physician Assistant Progress Note dated 08/21/25 revealed treatment orders for Resident #22's pyoderma included to apply a thick layer of gentamicin 0.1 % ointment to the red areas on her scalp and inside her nose twice a day until healed. On 09/30/25 between 9:00 A.M. and 9:13 A.M., observation revealed Resident #22 was laying in bed. The resident's pillow and wall next to her bed was observed to have brown staining and smears of blood. The resident's fingernails were observed to be jagged and dirty. The resident's scalp above her forehead was deep red with scattered patches and brown edges approximately 9.0 centimeters in width by 25 centimeters in length extending the length around her scalp from ear-to-ear. The skin was deep red with brownish edges and scattered open areas were observed to be bleeding. At the time of the observation, interview with Registered Nurse (RN) #213 stated the resident was being followed by the dermatologist for the area but did not know if the areas were currently infected. RN #213 was observed gathering treatment supplies including gentamicin and a pair of gloves. The resident was on enhanced barrier precautions and upon entering the room there was no isolation cart or gowns available for use. RN #213 removed her gloves and RN #216 brought a gown to RN #213 to wear during the treatment. RN #213 then donned new gloves and then put on the isolation gown without washing her hands. RN #213's gloves were observed under the cuff the isolation gown. RN #213 proceeded to arrange supplies and the resident for the treatment and was observed touching the resident's bedside table, personal items, pillow case and other items with her gloved hands. RN #213 used the same gloved hands to apply a thin layer of gentamicin cream to various areas of the resident's scalp. RN #213 then removed her gloves and washed her hands at the sink. At 9:13 A.M., interview with RN #213 verified the above observation. Review of the policy: Personal Protective Equipment - Non-Sterile Gloves revised 05/01/25 revealed donning non-sterile gloves included to perform hand hygiene and if gowning procedures are also being used, put gloves on after putting on the gown so that the cuff of the gloves can be pulled over the sleeve of the gown. Doffing non-sterile gloves was to be discarded and hand hygiene performed. Review of the undated policy: Hand Washing-Hygiene revealed alcohol/ antimicrobial hand rub may be used instead of hand washing before donning gloves, before performing any non-surgical invasive procedure and after removing gloves. The use of gloves does not replace hand washing or hand sanitizing.		