

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/31/2024
NAME OF PROVIDER OR SUPPLIER  Altercare Cambridge Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  66731 Old Twenty-One Road Cambridge, OH 43725	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</b></p> <p>Based on observation, medical record review, policy review and interview, the facility failed to maintain resident dignity for Resident #100. This affected one resident (#100) of three sampled residents. The facility census was 49.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #100 was admitted to the facility on [DATE] with a history of urinary tract infections and discharged to the hospital on 12/16/24. The resident returned to the facility on [DATE] with diagnoses including neurocognitive disorder with Lewy bodies, dementia, prostate cancer, obstructive uropathy, and an indwelling urinary catheter.</p> <p>Review of the 5-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #100 was cognitively intact for daily decision-making and utilized an indwelling urinary catheter.</p> <p>Review of the Physician Orders dated 12/30/24 revealed Resident #100 was ordered a suprapubic catheter to straight drainage.</p> <p>On 12/30/24 at 9:19 A.M., observation revealed Resident #100 and Resident #83 were sitting in wheelchairs in the lobby/TV area across from the nursing station. The resident's indwelling urinary catheter tubing was observed lying on the floor without a barrier under the resident's wheelchair. Yellow urine was observed in the uncovered collection drainage bag. Assistant Director of Nursing (ADON) #200 verified the above at the time of the observation and stated the drainage bag should be covered.</p> <p>Review of the policy titled Resident Rights, revised October 2016, revealed employees shall treat all residents with kindness, respect, and dignity.</p> <p>This deficiency is an incidental finding investigated under Complaint Number OH00160178.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28704</p> <p>Based on observation, medical record review, policy review and interview, the facility failed to ensure nail care was provided as needed for Resident #76. This affected one resident (#76) of three residents sampled for activities of daily living. The facility census was 49.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #76 was admitted on [DATE] with diagnoses including Alzheimer's disease, acute kidney failure, anxiety disorder, and delusions.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #76 was severely impaired for daily decision-making and required partial/moderate assistance to shower/bathe self and supervision/touching assistance with personal hygiene.</p> <p>Review of the Shower/Bath Schedules revealed Resident #76 received showers on the night shift on Mondays and Fridays.</p> <p>On 12/30/24 at 2:20 P.M., observation of Resident #76 revealed five of his fingernails were approximately 1.0-inch-long, orange in color and thick, two nails were jagged, and brown debris was observed under the nails.</p> <p>On 12/31/24 between 10:42 A.M. and 10:50 A.M., Resident #76 was observed sitting on his bed and appeared showered and hair washed. Observation revealed Resident #76's fingernails remained long, jagged with brown debris. At the time of the observation, Resident #76 was calm, pleasant, smiling and was able to answer screening questions appropriately. Resident #76 stated he had received a shower this morning and felt better. The resident stated he did not want long fingernails, but he didn't have any clippers to use especially to cut through his thick and tough fingernails. Resident #76 lifted his hands toward the surveyor and stated he felt like he was turning into a [NAME] and would like help cutting his fingernails. The surveyor stated she would notify staff of his request. Licensed Practical Nurse (LPN) #205 was sitting at the nurses' desk and was informed of the resident's request for nail care. LPN #205 and the surveyor went back to Resident #76's room, and Resident #76 told LPN #205 he would like to have his nails cut. LPN #205 was asked to look at the resident's fingernail and verified the above observation. LPN #205 asked the resident where his nail clippers were, and he stated he did not have any. LPN #205 informed Resident #76 she would help him cut his nails and left the room.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/31/24 at 11:15 A.M., observation with the Director of Nursing (DON), LPN #205, and Registered Nurse (RN) #211 revealed Resident #76's fingernails were trimmed, cut and clean. Resident #76 was sitting on his bed, calm and pleasant. The resident showed the surveyor his nails that had been cut and trimmed and stated he was happy that they looked good. The resident looked toward LPN #205 and said she helped cut his nails as she said she would when she had been in his room earlier with the surveyor. Resident #76 stated he was glad they were cut because sometimes he had poked himself in the eye with them because they were so long. On 12/31/24 at 11:18 A.M., the interview with RN #211 verified the above including Resident #76 stated he did not want long fingernails and was glad to have his nails cut.</p> <p>Review of the policy Shower/Tub Bath, revised 04/18/24, revealed it was the facility's policy to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Procedure included observing fingernails and cleaning debris from under fingernails as needed. Fingernails and toenails were not to be trimmed unless instructed by the supervisor. The nurse was to be notified if the resident refused a shower/bath, any new skin areas or any change in behaviors the resident exhibited in the shower.</p> <p>The facility did not have a specific nail care policy for review at the time of the survey.</p> <p>This deficiency is an incidental finding investigated under Complaint Number OH00160178.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28704</p> <p>Based on observation, medical record review, policy review and interview, the facility failed to ensure dependent residents were provided nail care as needed. This affected one resident (#100) of three sampled residents sampled. The facility census was 49.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #100 was admitted to the facility on [DATE] and discharged to the hospital on 12/16/24. The resident returned to the facility on [DATE] with diagnoses including heart failure, pulmonary embolism, non-traumatic brain injury, obstructive uropathy, and a history of urinary tract infections.</p> <p>Review of the 5-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #100 was cognitively intact for daily decision-making and required substantial/maximal assistance with bathing and hygiene.</p> <p>Review of the GG Support assessment dated [DATE] revealed prior functioning of self-care included Resident #100 was dependent for all activities of self-care.</p> <p>Review of the Nursing Assistant Bathing/Skin Tool dated 12/26/24 revealed hospice staff gave Resident #100 a shower. There was no documented evidence nail care was provided.</p> <p>On 12/30/24 at 9:19 A.M., observation revealed Resident #100 was sitting in a wheelchair in the lobby area across from the nursing station. Observation of Resident #100's hands revealed three nails were long, jagged and had a brown substance under the nails. The resident stated he did not know what it was. Assistant Director of Nursing (ADON) #200 was asked to look at the resident's hands and verified the above at the time of the observation.</p> <p>Review of the policy Shower/Tub Bath, revised 04/18/24, revealed it was the facility's policy to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Procedure included observing fingernails and cleaning debris from under fingernails as needed. Fingernails and toenails were not to be trimmed unless instructed by the supervisor. The nurse was to be notified if the resident refused a shower/bath, any new skin areas or any change in behaviors the resident exhibited in the shower.</p> <p>The facility did not have a specific nail care policy for review at the time of the survey.</p> <p>This deficiency is an incidental finding investigated under Complaint Number OH00160178.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>28704</p> <p>Based on observation, BIPA (Benefits Improvement and Protection Act) Report review, daily census report review, and interview, the facility failed to post accurate nurse staffing information as required. This had the potential to affect all 49 residents residing within the facility.</p> <p>Findings include:</p> <p>On 12/30/24 at 9:07 A.M., observation of the reception area revealed a BIPA Report dated 12/30/24 indicating the current census was 46. At 9:09 A.M., an interview with the Administrator stated he would need to double-check the census as the BIPA Report could change due to, he received this report from the corporate office. The Administrator stated the BIPA report currently posted had been printed out on 12/27/24 to cover through the weekend, including this one. BIPA Report postings were observed at the reception desk and both nursing stations.</p> <p>On 12/30/24 at 4:15 P.M. observation of the posted BIPA Reports dated 12/30/24 at two nursing stations and the reception area revealed the facility census was 46.</p> <p>Review of the Daily Census Report dated 12/30/24 revealed the facility census was 49.</p> <p>On 12/31/24 at 7:30 A.M., observation of the reception area revealed the posted BIPA Report was dated 12/30/24 with a census of 46. On 12/31/24 at 7:30 A.M., interview with Receptionist #215 verified the above posting.</p> <p>On 12/31/24 at 9:05 A.M., the interview with the Administrator verified the facility census on 12/30/24 was 49 and the BIPA Reports posted did not accurately reflect the daily census.</p> <p>This deficiency is an incidental finding investigated under Complaint Number OH00160178.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28704</p> <p>Based on observation, medical record review, policy review and interview, the facility failed to maintain adequate indwelling urinary catheter infection control practices for Resident #100. This affected one resident (#100) of three sampled residents. The facility identified three residents with the use of an indwelling urinary catheter. The facility census was 49.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #100 was admitted to the facility on [DATE] with a history of urinary tract infections and discharged to the hospital on 12/16/24. The resident returned to the facility on [DATE] with diagnoses including heart failure, pulmonary embolism, non-traumatic brain injury, obstructive uropathy and a history of urinary tract infections.</p> <p>Review of the 5-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #100 was cognitively intact for daily decision-making, utilized an indwelling urinary catheter, and had a urinary tract infection in last 30 days.</p> <p>Review of the Progress Note dated 12/24/24 revealed Resident #100 had a suprapubic catheter that was draining cloudy pale-yellow urine.</p> <p>Review of the Physician Orders dated 12/30/24 revealed Resident #100 was ordered a suprapubic catheter to straight drainage.</p> <p>On 12/30/24 at 9:19 A.M., observation revealed Resident #100 was sitting in a wheelchair in the lobby/TV area across from the nursing station. The resident's indwelling urinary catheter tubing was observed lying on the floor under the resident's wheelchair with yellow urine observed in the collection drainage bag. Assistant Director of Nursing (ADON) #200 verified the above at the time of the observation and stated the tubing should not be on the floor. On 12/30/24 at 10:25 A.M., an interview with ADON #200 stated the indwelling catheter tubing had been changed due to it being on the floor.</p> <p>On 12/30/24 at 10:01 A.M., an interview with Licensed Practical Nurse (LPN) #204 stated indwelling catheter tubing was not to be touching the floor.</p> <p>Review of the policy: Infection Control Program, dated November 2020, revealed the infection control program was utilized to implement prevention measures to control health care associated infections for the protection of our residents, families and employees.</p> <p>This deficiency is an incidental finding investigated under Complaint Number OH00160178.</p>		