STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366369	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Thornville Inc.	14100 Zion Road Thornville, OH 43076

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 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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to appropriately manage and treat a non pressure skin alteration for one (Resident #100) out of two residents with non pressure skin alterations and obtain daily weights on three (Resident #100, #400 and #500) of three residents reviewed for daily weights. The facility census was 47.Findings include:1.Review of the medical record for Resident #100, revealed an admission date of 02/26/25 and a discharge to home date of 07/03/25. Diagnoses included but were not limited to unspecified fracture of upper end of left tibia, unsteady on feet, muscle weakness, heart failure, chronic kidney disease, stage 3, and anxiety disorder with a new diagnosis of unspecified open wound to right foot 06/02/25.Review of the active care plan for Resident #100 dated 02/26/25 revealed a cardiac impairment related to congestive heart failure.Review of the active physician order for Resident #100 dated 02/26/25 revealed a daily weight once in the morning.Review of the care plan for Resident #300 dated 02/26/25 with interventions started on 03/12/25, revealed at risk for skin breakdown related to diabetes, impaired mobility, and renal disease with interventions including but not limited to observe/report any skin and symptoms of skin irritation such as lack of sensation, tingling or burning feeling, verbal/nonverbal signs of pain, discoloration, edema, excoriation, erythema, and report to physician as needed. Also revealed alteration in blood glucose metabolism related to diagnosis of insulin dependent diabetes mellitus with an intervention including but not limited to observe resident's feet for potential ulcer formation. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating intact cognition. This resident was also assessed o be at risk for pressure injuries. Review of the wound grid documentation for Resident #100 dated 06/02/25 at 12:51 P.M. by the Facility Wound Nurse #33 revealed a right third toe abrasion, red in color measured 2.2 centimeters (cm) X 1.6 cm X no depth documented.Further review of the wound grid documentation for this resident revealed no documentation of the fourth right toe trauma for 06/02/25. The date/time of being observed for an initial assessment by the Facility Wound Nurse #33 was 06/03/25 at 6:46 A.M. measured 2.1 cm X 1.9 cm X no depth documented and no description of the trauma area. Review of the medical record for Resident #100 did not reveal how the trauma to the right third and fourth toe occurred.Review of the active physician order for Resident #100 dated 06/02/25 at 12:56 P.M. with a discontinuation date of 06/04/25 at 7:00 A.M. by the Facility Wound Nurse #33 revealed a treatment for the right foot, second and third toe- cleanse with normal saline and pat dry. Apply xeroform and an island adhesive dressing daily.Review of the Treatment Administration Record (TAR) for Resident #100 for the date of 06/02/25 and 06/03/25 the treatment order was completed as ordered for the right foot third toe, but no treatment for the right foot fourth toe. Review of the medical record for Resident #100 revealed Wound Clinic visit notes dated 06/23/25 for Resident #100 revealed a right second, third and fourth toe diabetic ulcer all measured as one area at 8 cm X 1.5 cm X 0.2 cm. an order for the right second, third and fourth toe diabetic ulcer wounds to be cleansed with normal saline and to pack wounds with betadine-soaked gauze and apply a dressing daily. Review of the active physician order for Resident #100, dated 06/24/25, entered by the Facility Wound Nurse #33, with a discontinued date of 06/26/25 by the Director of Nursing (DON), revealed the right foot-leave dressing in place until next wound clinic appointment. Do not get wet. Cover for showers.Review of the TAR for Resident #100 revealed from 06/24/25 through 06/25/25, no dressing change was completed for the right second, third and fourth toe diabetic ulcer wounds.Interview on 08/05/25 at 10:25 A.M. with the Facility Wound Nurse #33 verified there was no documentation in Resident #100's medical record for the incident on 06/02/25 regarding the trauma to the right foot third and fourth toe. She interviewed the resident, and she could not remember how it happened. They concluded it must have happened when the resident accidentally dragged her right foot over a non-skid strip. Also verified she did not document the fourth right toe on 06/02/25 and should have as that was when it was discovered and should have been documented for description and measurements.Continued interview on 08/05/25 at 10:31 A.M. with the Facility Wound Nurse #33 verified for Resident #100, the order placed on 06/02/25 through 06/04 25 was a treatment for the right foot second and third toe when the second toe was not a concern, it was the fourth toe and it did not get any treatment for those days. Review of the daily weights in vital signs results for Resident #100 revealed since admission on [DATE], no daily weights were obtained on 03/03/25, 03/10/25, 03/11/25, 03/18/25, 05/13/25 and 06/25/25.2. Review of the medical record for Resident #400, revealed an admission date of 03/27/25. Diagnoses

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospital record review, wound notes, facility and staff interviews, wound physician interview, observation, review of the facility policies, and National Pressure Injury Advisory Panel (NPIAP) information, the facility failed to develop and implement an accurate comprehensive and individualized pressure ulcer program to ensure necessary care and services to prevent the worsening of pressure ulcers for Resident #800 and #300. This affected two residents (#800 and #300) of two residents reviewed for pressure ulcers. The facility census was 47. This resulted in Immediate Jeopardy and serious life-threatening harm to Resident #800, who was assessed as requiring maximum assistance with bed mobility and transfers and was at risk for pressure ulcer development, on 05/04/25 when treatment orders for known pressure ulcers were not obtained timely, orders were entered incorrectly resulting in wrong treatments and pressure ulcer worsening and prevention care was not in place leading to an admission to the hospital for subsequent infection/sepsis. Resident #800 was ultimately placed on hospice due to multiple antibiotic use from worsening of pressure ulcers. This also resulted in Immediate Jeopardy and serious life-threatening harm to Resident #300, who was assessed as requiring maximum assistance with bed mobility and transfers and at risk for pressure ulcer development, on 06/24/25 when the resident was assessed to have a stage 4 (full thickness skin and tissue loss with exposed palpable fascia, muscle, tending, ligament, cartilage or done in the ulcer; slough and/or eschar may be visible) pressure ulcer to the right buttock that previously was a stage 3 (full thickness loss of skin, in which adipose [fat] is visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present; fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed) the week prior, due to medicated treatments not being placed in the orders for administration from 06/19/25 through 06/23/25. On 08/11/25 at 1:11 P.M., Administrator #41, Regional Nurse #68, Director of Nursing (DON) #40, and Regional Administrator #69 were notified Immediate Jeopardy began on 05/04/25 when the facility failed to provide any treatments as well as accurate treatments and necessary interventions to prevent worsening of pressure ulcers resulting in the hospitalization of Resident #800 for infection/sepsis from pressure ulcers. Resident #800 returned to the facility on [DATE] and was sent back to the hospital for continued inaccurate treatments and necessary interventions to prevent worsening of pressure ulcers on 06/27/25. Resident #800 returned to the facility on [DATE] and was ultimately placed on hospice due to multiple antibiotic use from worsening of pressure ulcers. Immediate Jeopardy also occurred on 06/24/25 when the facility failed to provide the medicated treatment of Leptospermum Honey and Alginate Calcium to be applied daily with a gauze island bordered dressing from 06/19/24 through 06/23/25 to a right buttock stage 3 pressure ulcer measuring 6.8 centimeters (cm) long, 5.4 cm wide and 0.2 cm in depth with moderate serous exudate and 50 percent necrotic tissue. On 06/24/25, the right buttock pressure ulcer was assessed to have worsened to a stage 4 and measured 7 cm long, 5.4 cm wide, and undetermined depth with 20 percent black necrotic(dead) eschar tissue, 50 percent devitalized necrotic tissue and 20 percent slough (dead tissue separating from living tissue). The immediate Jeopardy was removed on 08/11/25 when the facility implemented the following corrective actions: On 08/07/25, Resident #300 was assessed by Wound Care Physician #70 with orders received and followed by a licensed nurse, Assistant Director of Nursing (ADON)/Wound Nurse# 33. On 08/07/25, Resident #800 was assessed by Wound Physician #70 with new orders received and followed by a licensed nurse ADON/Wound Nurse# 33. On 08/07/25 at 10:00A.M., an in-service was completed for ADON/Wound Nurse #33 by DON #40 and Regional Nurse #68 on the policy of Pressure Injuries: assessment, prevention, and treatment and the policy of physician notification. On 08/07/25 at 11:30A.M., an in-service was completed for Minimum Data Set (MDS) Nurse #42, Registered Nurse (RN) #34, RN #27, RN #56, Licensed Practical Nurse (LPN) #44, LPN #25, LPN # 65, LPN #30, and 26 Certified Nursing Assistants (CNA) by DON #40 on the policy of pressure Injuries: assessment, prevention, and treatment policy; completing head to toe assessment and documenting on skin sheet, if resident has skin alterations; documenting the initial wound observation; and contacting House Physician #66 to obtain treatment orders if not provided from the hospital. Any staff who had not received education as of 08/11/25 will not work until education is completed. All staff had received the education as of 08/11/25. On 08/07/25 at 11:30A.M., an in-service was completed for MDS Nurse #42, RN #34, RN #27, RN #56, LPN #44, LPN #25, LPN # 65, LPN #30 by the DON #40 on notifying physician of any resident change in condition. Any staff who have not received education as of 08/11/25 will not work until education is

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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. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to ensure residents had effective pain assessments and management. This affected three (Resident #100, #300, and #800) of three residents reviewed for pain. The facility census was 47. Findings include:1.Review of the medical record for Resident #100, revealed an admission date of 02/26/25 and a discharge to home date of 07/03/25. Diagnoses included but were not limited to unspecified fracture of upper end of left tibia, unsteady on feet, muscle weakness, heart failure, chronic kidney disease, stage 3, and anxiety disorder with a new diagnosis of unspecified open wound to right foot 06/02/25 and sepsis 06/10/25.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating intact cognition. Review of the care plan dated 02/26/25 for Resident #100 revealed actual alteration in comfort/pain related to unspecified pain with interventions including but not limited to administer pain medications as ordered/observe for effectiveness and observe for episodes of breakthrough pain and medicate as ordered.Review of the physician orders dated 06/10/25 for Resident #100 revealed oxycodone-acetaminophen 5-325 milligram (mg) one tablet orally every 8 hours as needed for pain on a scale of 5-10 (0 being none and 10 being the worst.Further review of the physician orders revealed no other pain medication ordered as needed for this resident.Review of the medical record for Resident #100 revealed a skin alteration occurred on 06/02/25 at the facility per facility wound grid documentation.Further review revealed in the progress notes, starting on 06/03/25, a wound review: weekly review of this resident's pain scale related to the wound, with a treatment, documented by the Facility Wound Nurse #33. The dates with the pain scales and treatment as medication were: 06/03/25 with a pain rating of 4, 06/10/25 with a pain rating of 5, 06/17/25 with a pain rating of 3 and 06/24/25 with a pain rating of 3.Review of the medication administration record (MAR) for Resident #100 for 06/10/25 pain rating of a 5 revealed no administration of the oxycodone-acetaminophen 5-325 mg.Further review of the MAR revealed for the other dates this resident had wound pain no medications were administered.2.Review of the medical record for Resident #300, revealed an admission date of 05/20/25. Diagnoses included but were not limited to metabolic encephalopathy, altered mental status, muscle weakness, and cerebral infarction.Review of the most recent MDS 3.0 assessment dated [DATE] revealed a BIMS of 14 out of 15 which indicated intact cognition. cognitive intactness. This resident was also assessed to have unhealed pressure ulcers.Review of the care plan dated 05/20/25 for Resident #300 revealed actual alteration in comfort/pain related to abnormal posture with interventions including but not limited to administer pain medications as ordered/observe for effectiveness and observe for episodes of breakthrough pain and medicate as ordered.Review of the physician's orders for Resident #300 revealed for the dates of 05/20/25 through 07/31/25, no as needed pain medications were ordered.Review of the medical record for Resident #300 revealed a skin alteration on admission to the facility per facility wound grid documentation.Further review revealed in the progress notes, starting on 05/27/25, a wound review: weekly review of this resident's pain scale related to the wound, with a treatment, documented by the Facility Wound Nurse #33. The dates with pain scales and treatment as medications were: 06/17/25 pain rating of 4, 06/19/25 pain rating of 4, 06/24/25 pain rating of 3, 07/15/25 pain rating of 4, 07/22/25 pain rating of 4, 07/24/25 pain rating of 3 and 07/31/25 pain rating of 4.3. Review of the medical record for Resident #800, revealed an admission date of 04/18/25. Diagnoses included but were not limited to weakness, cerebral infarction, atrial fibrillation, type 2 diabetes, and chronic kidney disease. Review of the most recent MDS 3.0 assessment dated [DATE] revealed a BIMS of 14 out of 15 indicating cognitive intactness. This resident was also assessed to have a pressure ulcer injury.Review of the care plan dated 04/18/25 for Resident #800 revealed actual alteration in comfort, pain related to pressure ulcers with interventions including but not limited to administer pain medications as ordered/observe for effectiveness and observe for episodes of breakthrough pain and medicate as ordered.Review of the physician's orders dated 04/21/25 for Resident #800 revealed the pain medication of hydrocodone-acetaminophen 5-325mg tablet, one tablet every six hours as needed for severe pain of 6-10.Further review of the orders also revealed for this resident dated 04/23/25, acetaminophen 325 mg tablet, one tablet every 6 hours for mild pain rating 1-5.Further review revealed in the progress notes, starting on 04/22/25 and ending on 05/13/25, a wound review: weekly review of this resident's pain scale related to the wound, with a treatment, documented by the Facility Wound Nurse #33 were not completed weekly for pain assessment. Further

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review and interview, the facility failed to ensure the facility medication administration error rate was not more than five percent. This affected one resident (#42) of eight residents observed for medication administration with four errors out of 25 opportunities resulting in an error rate of 16%. The census was 47. Findings include: Medical record review revealed Resident #42 was admitted on [DATE] with diagnoses including wedge compression thoracic vertebra fractures, depression, anxiety, atherosclerotic heart disease and constipation. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #42 was moderately impaired for daily decision-making. Review of the electronic Physician Orders dated 09/25/25 revealed medications to be administered included chewable aspirin 81 milligrams (mg) for prophylaxis, buspirone 10 (mg) for sadness/anxiety, I-vite (vitamin and mineral) for supplement and senna plus 8.6-50,mg for bowel regimen, bupropion SR 150 (mg), celexa 40 (mg), culturelle 15 billion cell, lactulose 10 grams, aspercreme lidocaine patch, lisinopril 10mg, OsCal 500 (mg) with Vit D3, Miralax 17 gm, and Vitamin C 500 (mg). On 09/25/25 between 8:00 A.M. and 8:14 A.M., observation revealed Registered Nurse (RN) #200 prepared and administered Resident #42's morning medications including enteric coated aspirin 81 (mg), buspirone 5 (mg), and senna 8.5 (mg) and I-vite was not dispensed or administered during the observation. RN #200 was observed leaving her medication administration record open upon entering the resident's room and the electronic MAR was positioned across from the nursing station and not within eye sight of the nurse. RN #200 also left the sealed Aspercreme lidocaine patch on top of the medication cart unsupervised when she went to the resident's room to administer the other medications. At the time of the observation, RN #200 verified she left the Aspercreme lidocaine patch unattended on the top of the medication cart. On 09/25/25 at 2:46 P.M., interview with RN #200 verified she documented she had administered I-Vite to the resident; however she did not administer the medication. RN #200 verified she administered enteric coated ASA and senna to Resident #42 because that was the only form of the medications available to administer in her medication cart, and the buspirone order had been changed from 5 (mg) to 10 (mg) and the old bubble pack containing the 5 (mg) dose was left in the medication cart without a label indicating directions had been changed. RN #200 verified she had not given the ordered dose. RN #200 was observed removing the buspirone 5 (mg) bubble pack from the medication cart, closed the cart drawer, did not lock the medication cart, walked to the medication/storage room beside the nursing station with the bubble pack, unlocked the door and entered the medication/storage room with the door closing behind her. No staff were noted to be within the vicinity of the medication cart and the cart remained unlocked. RN #200 verified the cart was unlocked when she came back out of the medication/storage room. Review of the policy: Specific Medication Administration Procedures dated May 2020 revealed medications were to be administered in a safe and effective manner, all medication storage areas including carts were to be locked at all times unless in use and under the direct observation of approved facility or pharmacy personnel. If medication instructions are changed during the course of therapy, it was the nurse's responsibility to add a direction change notation/sticker directly on the product to indicate as such.

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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 interviews and record reviews, the facility failed to maintain an up to date and complete medical record for three residents (#100, #300 and #800) of three residents reviewed for receiving wound care from an outside wound consultant group. The facility census was 47. Findings include:1.Review of the medical record for Resident #100, revealed an admission date of 02/26/25 and a discharge to home date of 07/03/25. Diagnoses included but were not limited to unspecified fracture of upper end of left tibia, unsteady on feet, muscle weakness, heart failure, chronic kidney disease stage 3, and anxiety disorder with a new diagnosis of unspecified open wound to right foot 06/02/25 and sepsis 06/10/25.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed resident had intact cognition with a Brief Interview for Mental Status (BIMS) of 15 out of 15. Review of the medical record for Resident #100 revealed a skin alteration occurred on 06/02/25 at the facility per facility wound grid documentation.Further review revealed no Wound Physician visits in her closed record to review.Interview on 08/04/25 at 12:02 P.M. with the Director of Nursing (DON) revealed Resident #100 saw the Wound Physician group a few times during her stay and will get the visit notes from the Facility Wound Nurse #33 as they were not in her chart. 2. Review of the medical record for Resident #300, revealed an admission date of 05/20/25. Diagnoses included but were not limited to metabolic encephalopathy, altered mental status, muscle weakness, and cerebral infarction. Review of the most recent MDS 3.0 assessment dated [DATE] revealed resident had intact cognition with a BIMS of 14 out of 15. Review of the medical record for Resident #300 revealed a skin alteration on admission per facility wound grid documentation.Further review revealed no Wound Physician visits in the record to review.Interview on 08/06/25 at 11:09 A.M. with the Facility Wound Nurse #33 verified Resident #300 did not have any of her Wound Physician visits in her current medical record and should be uploaded after each visit.3. Review of the medical record for Resident #800, revealed an admission date of 04/18/25. Diagnoses included but were not limited to weakness, cerebral infarction, atrial fibrillation, type 2 diabetes, and chronic kidney disease.Review of the most recent MDS 3.0 assessment dated [DATE] revealed resident with intact cognition with a BIMS of 14 out of 15. Review of the medical record for Resident #800 revealed a skin alteration on admission per facility wound grid documentation.Further review revealed no Wound Physician visits in the medical record to review.Interview on 08/06/25 at 1:50 P.M. with Regional Nurse #68 verified Resident #800 did not have the Wound Physician Consultant notes uploaded into their charts and had to access them on the consultant's server, but it is the expectation that the Facility Wound Nurse #33 be uploaded after each visit to keep the residents' chart up to date and current for care.This was an incidental finding discovered during the course of this complaint investigation.

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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. Based on observation, interview and facility policy reviews, the facility failed to ensure proper hand hygiene and medical equipment was sanitized before and after resident use. This affected two residents (#701 and #802), but has the potential to affect all 47 residents residing in the facility. Findings include:Observation on 08/05/25 at 8:35 A.M. with Registered Nurse (RN) #27 revealed her to be preparing medications for Resident #701. She put on a glove to her right hand and proceeded to touch the cart, the residents' medications and the computer all with the same glove on. Once the medications were in the cup, she removed the glove, did not sanitize her hands after locking the cart and entering Resident #701's room. She took Resident #701's blood pressure and pulse ox with a machine she brought into the room. She then administered the residents' medications and proceeded to leave the room without sanitizing her hands and cleaning off the equipment. She returned to the cart at 8:48 A.M. and proceeded to prepare Resident #802's medications following the same steps. She put on a glove to her right hand, proceeded to touch the cart, medications and computer with the same glove, then removed her glove, locked the cart and did not sanitize her hands before entering Resident #802's room to administer medications. She took Resident #802's blood pressure and pulse ox with the same machine she carried into the rooms and did not sanitize them before or after use. She administered Resident #802's medications and left the room without sanitizing her hands.Interview on 08/05/25 at 9:00 A. M. with Registered Nurse #27 verified she should have changed her glove once she touched anything other than Resident #701 and #802's medications, she should have sanitized her hands before and after entering the resident's rooms and she verified she never cleaned the blood pressure and pulse ox equipment before and after each resident.Review of the facility policy titled Hand Washing-Hygiene no date, revealed it is the facility's policy for employees to conduct proper hand hygiene that will aid in the prevention and transmission of infectious diseases. Alcohol/Antimicrobial hand rub may be used in the following situations: before donning gloves, after removing gloves and before preparing or handling medications.Review of the facility policy titled Cleaning of Equipment no date revealed the facility will utilize general disinfecting procedures to prevent and control infection.This was an incidental finding discovered during the investigation for Complaint Number 1385838.