

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Altercare Thornville Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on observation, resident interview, staff interview, and policy review, the facility failed to ensure Resident #3 was treated with with dignity during and after dining. This affected one (Resident #3) of one resident reviewed for dignity. The facility census was 49.</p> <p>Findings include:</p> <p>Record review revealed Resident #3 admitted to the facility on [DATE] with diagnoses including heart failure, dysphagia, bipolar disorder, need for assistance with personal care, and intracranial injury without loss of consciousness.</p> <p>Review of the care plan, dated 08/06/21, revealed Resident #3 was to receive supervision during meals or food activities, as needed, and given verbal cues for chewing or swallowing.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 10/02/24, revealed Resident #3's cognition remained intact and she had no behaviors. The resident required setup or clean-up assistance for eating, was dependent on staff for dressing, and required maximum assistance for personal hygiene.</p> <p>Observation on 11/12/24 at 10:37 A.M. revealed Resident #3 was sitting in her wheelchair in the hallway with food and stains on her shirt, pants, wheelchair cushion, and the floor beneath her. Resident #3 was not wearing a clothing protector. On Resident #3's tray table, there was a two-handled cup with a lid and a spout.</p> <p>Interview on 11/12/24 at 10:37 A.M. with Resident #3 revealed she had to eat in the hallway so the nurse could keep an eye on her because of a recent choking related incident.</p> <p>Observation on 11/12/24 at 12:05 P.M. revealed Resident #3 was in the dining room with two beverages in the two-handled cups with lids and spouts. A dark brown liquid was dribbling down Resident #3's chin. At 12:12 P.M., another resident assisted Resident #3 by using a napkin to clean her face.</p> <p>Observation on 11/13/24 at 10:31 A.M. revealed Resident #3 was seated in the cafe drinking hot chocolate from a two-handled cup with a lid and a spout. The residents purple shirt was damp with spots and stains from the hot chocolate.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 11/13/24 at 4:19 P.M. revealed Resident #3 sitting in the dining room for dinner and wearing a purple shirt with dark brown stains. Resident #3 was wearing a clothing protector and had two, two-handled cups with lids and spouts. When Resident #3 would attempt to take a drink, she had tremors which caused the liquid to shake and splash out of the spout, leaving the drink dribbling down her chin. Resident #3 was served a plate of spaghetti with meat balls and marinara sauce, and the aide cut up the meatballs, but not the noodles. Resident #3 struggled to get the noodles on the weighted utensils and then get the food to her mouth. She continuously dropped noodles on her shoes, socks and on the floor. Resident #3 continued to struggle with eating for approximately five minutes before staff intervened.</p> <p>Interview on 11/13/24 at 4:47 P.M. with Assistant Director of Dietary Services (ADDS) #305 confirmed Resident #3 had dropped food onto herself, including on her shoes.</p> <p>Interview and observation on 11/14/24 at 7:51 A.M. with Resident #3 revealed she was bothered by sitting in the hallway with food and stains on her clothes, wheelchair, and the floor around her, because she did not want people to see her like that. At the time of the interview, Resident #3 was wearing shoes with marinara sauce on them from the previous nights' dinner. The resident was also sitting on a dirty wheelchair cushion caked with food debris.</p> <p>Interview on 11/14/24 at 8:00 A.M. with Regional Nurse Consultant (RNC) #302 confirmed Resident #3's shoes and wheelchair cushion had food debris from the previous night.</p> <p>Interview on 11/14/24 at 8:38 A.M. with Registered Nurse (RN) #160 revealed Resident #3 could get messy during meals and RN #160 would attempt to help her clean up. RN #160 stated she did not feel it was very dignified for Resident #3 to sit in dirty clothes.</p> <p>Review of a policy titled Resident Rights, updated October 2016, revealed the facility's policy was to treat all residents with kindness, respect, and dignity and staff were to make all attempts to ensure residents were treated with kindness, respect, and dignity.</p>		

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<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008</p> <p>Based on record review, staff interview and facility policy, the facility failed to ensure that advanced directives were prominently placed in Resident #100's and Resident #149's medical records. This affected two (Resident #100 and Resident #149) of two residents reviewed for advanced directives. The facility census was 49.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #100 was admitted on [DATE] with diagnoses that included surgical aftercare of the digestive system, intestinal obstruction, anemia, depression, gastroesophageal reflux, and malignant neoplasm of the prostate.</p> <p>Review of Resident #100's electronic and physical medical records revealed that a code status was not prominently displayed in either chart.</p> <p>Interview with Registered Nurse (RN) Supervisor #162 on [DATE] at 3:52 P.M. confirmed there were no advanced directives prominently displayed in Resident #100's medical chart. RN Supervisor #162 was unable to identify the code status of Resident #100. RN Supervisor #162 stated that advanced directives were normally found in the front section of the chart.</p> <p>Interview with the Director of Nursing (DON) on [DATE] at 3:57 P.M. also confirmed that there were no advanced directives prominently displayed in Resident #100's medical chart.</p> <p>Review of the facility's policy titled, Advanced Directives, revised [DATE], revealed prior to or upon admission of a resident to the facility, staff should offer the opportunity to form advanced directives or inquire about existing advanced directives. It also revealed if the resident were to indicate that he or she had issued advanced directives about his or her care, documentation of such directive would be recorded in the medical record, and a copy of such directive would be included in the resident's medical record.</p> <p>47985</p> <p>2. Record review revealed Resident #149 admitted to the facility on [DATE] with diagnoses including altered mental status, dementia, and congestive heart failure.</p> <p>Review of the electronic medical record and the paper chart revealed Resident #149's code status was not displayed prominently in the medical record.</p> <p>Interview on [DATE] at 3:59 P.M. with the Director of Nursing (DON) confirmed Resident #149's medical records were missing the code status'. She revealed Resident #149 had a code status of Full Code (a medical directive that indicated cardiopulmonary resuscitation (CPR) should be used during the residents care in the event of such emergency) in place, which was now being added to the medical records.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Advanced Directives, revised [DATE], revealed prior to or upon admission of a resident to the facility, staff should offer the opportunity to form advanced directives or inquire about existing advanced directives. It also revealed if the resident were to indicate that he or she had issued advanced directives about his or her care, documentation of such directive would be recorded in the medical record, and a copy of such directive would be included in the resident's medical record.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on record review, observation, interview, and policy review, the facility failed to provide a homelike environment and ensure resident equipment was clean and well maintained. This affected four (#3, #13, #37, and #42) of four residents reviewed for environment. The facility census was 49.</p> <p>Findings included:</p> <p>1. Record review revealed Resident #3 admitted to the facility on [DATE] with diagnoses including heart failure, dysphagia, bipolar disorder, need for assistance with personal care, and intracranial injury without loss of consciousness.</p> <p>Observation on 11/12/24 at 8:39 A.M. revealed Resident #3 was sitting in her wheelchair in the hallway and the wheelchair cushion was caked in food debris and the extended brakes had frayed, gray duct tape on them.</p> <p>Interview on 11/14/24 at 8:00 A.M. with Regional Nurse Consultant #302 confirmed Resident #3's wheelchair cushion was caked in food debris and the extended brakes had frayed, gray duct tape on them.</p> <p>Interview on 11/14/24 at 8:46 A.M. with Physical Therapy Assistant #423 confirmed the tape on Resident #3's extended brakes was frayed. She stated the tape was applied to the brakes for visual cue and the brakes needed new tape.</p> <p>Review of the policy titled General Environmental Policies, dated November 2020, revealed the facility should be maintained in a clean and sanitary manner.</p> <p>2. Record review revealed Resident #13 admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, cognitive communication deficit, and dementia.</p> <p>Observation on 11/12/24 at 9:06 A.M. revealed Resident #13's room smelled strongly of urine.</p> <p>Interview on 11/13/24 at 10:23 A.M. with the Minimum Data Set (MDS) Nurse #118 confirmed Resident #13's room smelled strongly of urine.</p> <p>Review of the policy titled General Environmental Policies, dated November 2020, revealed the facility should be maintained in a clean and sanitary manner.</p> <p>3. Record review revealed Resident #37 admitted to the facility on [DATE] with diagnoses including cerebral infarction, dementia, and atherosclerotic heart disease.</p> <p>Observation on 11/12/24 at 9:13 A.M. revealed Resident #37's bathroom floor had a dark gray stain, approximately three feet long, in front of the toilet, and there was dark brown discolored caulking around the toilet and shower.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 11/14/24 at 8:19 A.M. with Lead Receptionist #146 confirmed Resident #37's floor was stained and the caulking was brown and discolored. Receptionist #146 stated she had attempted to scrub the floors but the stains would not come up.</p> <p>Review of the policy titled General Environmental Policies, dated November 2020, revealed the facility should be maintained in a clean and sanitary manner.</p> <p>4. Record review revealed Resident #42 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, depression, and hypertension.</p> <p>Observation on 11/12/24 at 8:48 A.M. revealed Resident #42's bathroom floor was dirty, stained, and had debris on it. There was brown discolored caulking around the shower and toilet, and there were two pink plastic containers on the floor with leaves and dust in them.</p> <p>Interview on 11/14/24 at 8:16 A.M. with Activity Director #164 confirmed Resident #42's floors were stained, the bathroom floor had a build-up of grime, the caulking around the shower and toilet was discolored, and there were pink containers with leaves and dust on the floor.</p> <p>Review of the policy titled General Environmental Policies, dated November 2020, revealed the facility should be maintained in a clean and sanitary manner.</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>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on observation, resident interview, staff interview, and policy review, the facility failed to ensure Resident #3 was provided with adaptive equipment for meals per physician orders. This affected one (Resident #3) of one resident reviewed for adaptive equipment. The facility census was 49.</p> <p>Findings include:</p> <p>Record review revealed Resident #3 admitted to the facility on [DATE] with diagnoses including heart failure, dysphagia, bipolar disorder, the need for assistance with personal care, and intracranial injury without loss of consciousness.</p> <p>Review of the care plan, dated 08/06/21, revealed Resident #3 should receive supervision during meals or food activities, as needed, and given verbal cues for chewing or swallowing. The care plan dated 07/28/21 revealed the resident was at risk for altered nutrition related to tremors, dysphagia, and the need for adaptive equipment to facilitate self feeding with interventions that included to apply a left handed weighted glove and a left handed curved spork supplied by the kitchen and for adaptive feeding equipment as ordered per the physician.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 10/02/24, revealed Resident #3's cognition remained intact and she had no behaviors. The resident required setup or clean-up assistance for eating, was dependent on staff for dressing, and required maximum assistance for personal hygiene.</p> <p>Review of physician orders revealed Resident #3 had an order in place, dated 08/28/24, for a regular plate with plate guards, built up curved utensils, and left upper extremity weighted glove for all meals. Resident #3 also had an order in place, dated 10/28/24, for a no added salt diet with a regular texture and thin liquids in handled cups with straws, a plate with guards, and small portions.</p> <p>Observation on 11/12/24 at 10:37 A.M. revealed Resident #3 was sitting in her wheelchair in the hallway with food and stains on her shirt, pants, wheelchair cushion, and the floor beneath her. Resident #3 was not wearing a clothing protector. On Resident #3's tray table, there was a two-handed cup with a lid and a spout.</p> <p>Interview on 11/12/24 at 10:37 A.M. with Resident #3 revealed she had to eat in the hallway so the nurse could keep an eye on her because of a recent choking related incident.</p> <p>Observation on 11/12/24 at 12:05 P.M. revealed Resident #3 was in the dining room with two beverages in the two-handed cups with lids and spouts. A dark brown liquid was dribbling down Resident #3's chin. At 12:12 P.M., another resident assisted Resident #3 by using a napkin to clean her face. Resident #3 did not have a left upper extremity weighted glove on for the lunch meal.</p> <p>Observation on 11/13/24 at 10:31 A.M. revealed Resident #3 was seated in the cafe drinking hot chocolate from a two-handed cup with a lid and a spout. The residents purple shirt was damp with spots and stains from the hot chocolate.</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>Observation on 11/13/24 at 4:19 P.M. revealed Resident #3 sitting in the dining room for dinner and wearing a purple shirt with dark brown stains. Resident #3 was wearing a clothing protector and had two, two-handled cups with lids and spouts. When Resident #3 would attempt to take a drink, she had tremors which caused the liquid to shake and splash out of the spout, leaving the drink dribbling down her chin. Resident #3 was served a plate of spaghetti with meat balls and marinara sauce, and the aide cut up the meatballs, but not the noodles. Resident #3 struggled to get the noodles on the weighted utensils and then get the food to her mouth. She continuously dropped noodles on her shoes, socks and on the floor. Resident #3 continued to struggle with eating for approximately five minutes before staff intervened. Resident #3 was not wearing a left upper extremity weighted glove for dinner.</p> <p>Interview on 11/13/24 at 4:47 P.M. with Assistant Director of Dietary Services (ADDS) #305 confirmed Resident #3 had orders in place for a left upper extremity weighted glove and cups with handles and a straw. ADDS #305 also confirmed Resident #3 did not have either pieces of her adaptive equipment during the dinner meal and that he had not ever heard of a weight glove. ADDS #305 stated Resident #3 had been making a mess and having a hard time eating, so he requested a therapy referral to nursing. ADDS #305 further confirmed Resident #3 had dropped food onto herself, including on her shoes.</p> <p>Interview and observation on 11/14/24 at 7:51 A.M. with Resident #3 revealed she was bothered by sitting in the hallway with food and stains on her clothes, wheelchair, and the floor around her, because she did not want people to see her like that. At the time of the interview, Resident #3 was wearing shoes with marinara sauce on them from the previous nights' dinner. The resident was also sitting on a dirty wheelchair cushion caked with food debris.</p> <p>Review of a policy titled Adaptive Equipment, revised November 2016, revealed assistive devices shall be offered to residents requiring them to maintain or improve their ability to eat independently. Residents were to be evaluated by therapy to determine the need for assistive devices and obtain a physician's order for the equipment. The tray card and care plan shall be changed to reflect the appropriate assistive devices and nursing would ensure the resident was able to properly use the equipment.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on record review, observations, interviews, review of facility policy, and review of equipment manuals, the facility failed to ensure alternating air mattresses were functional and set on the correct settings for pressure ulcer/injury prevention. This affected two (Resident #12 and Resident #13) of six residents reviewed for skin interventions. The facility census was 49.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #12 admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, dysphagia, dementia, and chronic obstructive pulmonary disease. Resident #12's record revealed the resident did not have any pressure ulcers. The record further revealed Resident #12 was 114.5 pounds on 06/07/23. Resident #12 was receiving hospice services and did not have additional weights in the record.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 08/31/24, revealed Resident #12 had a pressure reduction device on her bed.</p> <p>Review of the care plan, dated 01/19/23, revealed Resident #12 was at risk for pressure ulcers/injury related to senile degeneration of brain, heart failure, hyperlipidemia, hypertension, dementia, polyarthritis, and moderate protein-calorie malnutrition. Interventions included, but were not limited to, utilizing an air mattress that could be adjusted to resident comfort.</p> <p>Review of physician orders, dated 01/19/23, revealed Resident #12 had an order for an alternating air mattress to prevent skin breakdown.</p> <p>Observation on 11/12/24 at 8:43 A.M. revealed Resident #12 had an alternating air mattress in place which was unplugged, and the settings were turned to 210 pounds. Resident #12 appeared to weigh less than 210 pounds.</p> <p>Interview on 11/13/24 at 10:28 A.M. with the MDS Nurse #118 confirmed the alternating air mattress was set to 210 pounds.</p> <p>Interview on 11/13/24 at 10:28 A.M with Certified Nursing Assistant (CNA) #130 confirmed the bed had been unplugged, but she had just plugged the bed back in.</p> <p>Review of an undated policy titled, Pressure Injuries: Assessment, Prevention & Treatment, revealed the facility identified residents at risk for developing pressure injuries, implements interventions, and providing care for existing injuries. Interventions included, but were not limited to, using pressure redistribution mattresses.</p> <p>Review of the manual titled, Alternating Pressure and Low Air Loss Mattress Replacement System, revealed the Med Aire Edge Mattress Replacement System was a high quality powered air support surface that was specifically designed for the prevention and treatment of pressure injuries while optimizing patient comfort.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review revealed Resident #13 admitted to the facility on [DATE] with diagnoses including senile degeneration of brain, cognitive communication deficit, and dementia. Resident #13's record revealed the resident did not have any pressure ulcers. Resident #13 was receiving hospice services and there were no recent weights recorded in the medical record.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 10/20/24, revealed Resident #13 had a pressure reducing device for her bed.</p> <p>Review of the care plan, dated 05/03/19, for Resident #13 revealed the resident was at risk for skin breakdown related to impaired mobility, impaired cognition, and incontinence, with interventions that included an air mattress.</p> <p>Review of physician orders, dated 11/14/24, revealed Resident #13 had an order in place for an air mattress to the bed surface.</p> <p>Observation on 11/12/24 at 9:06 A.M. revealed Resident #13's alternating air mattress was set to static, normal pressure at 225 pounds.</p> <p>Interview on 11/13/24 at 10:23 A.M. with MDS Nurse #118 confirmed the alternating air mattress was set to 225 pounds, and Resident #13 was likely less than 225 pounds.</p> <p>Review of an undated policy titled, Pressure Injuries: Assessment, Prevention & Treatment, revealed the facility identified residents at risk for developing pressure injuries, implements interventions, and providing care for existing injuries. Interventions included, but were not limited to, using pressure redistribution mattresses.</p> <p>Review of the manual titled, Alternating Pressure and Low Air Loss Mattress Replacement System, revealed the Med Aire Edge Mattress Replacement System was a high quality powered air support surface that was specifically designed for the prevention and treatment of pressure injuries while optimizing patient comfort.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538</p> <p>Based on review of medical records, observation, and staff interview the facility failed to ensure fall interventions were in place for Resident #8 per the plan of care. This affected one resident (Resident #8) of two residents reviewed for falls. The facility census was 49.</p> <p>Findings include:</p> <p>Review of Resident #8's medical record revealed an admitted [DATE] and diagnoses including senile degeneration of the brain, dementia, depression, and a history of traumatic brain injury.</p> <p>Review of the physician orders for Resident #8 revealed on 11/09/23, the resident was ordered non-skid strips to the floor in front of the resident's toilet.</p> <p>Review of Resident #8's the care plan, dated 06/05/24, revealed the resident was at risk for falls/injury related to history of falls, incontinence, altered mental status, and impaired gait. Interventions included non-slip strips to the floor in front of the toilet.</p> <p>Observation of Resident #8's bathroom on 11/13/24 at 2:28 P.M. revealed non-skid strips were not present in front of the residents toilet.</p> <p>Interview on 11/13/24 at 2:50 P.M. with the Assistant Director of Nursing (ADON) #127 verified an order for non-skid strips in front of toilet was present in the medical record and she also verified the non-skid strips were not present in front of Resident #8's toilet. ADON #127 further verified that Resident #8 still utilized the toilet in her bathroom.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Altercare Thornville Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on observation, staff interview, and policy review, the facility failed to store respiratory equipment in a sanitary manner. This affected one (Resident #42) of one resident reviewed for respiratory equipment. The facility census was 49.</p> <p>Findings included:</p> <p>Record review revealed Resident #42 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, depression, and hypertension.</p> <p>Review of physician orders revealed an order, dated 04/28/24, for Ipratropium-Albuterol solution for nebulization 0.5 milligrams to 3 milligrams for inhalation due to wheezing, cough and congestion every six hours as needed.</p> <p>Observation on 11/12/24 at 10:57 A.M. revealed Resident #42's nebulizer was placed on her floor, plugged into the wall. The nebulizer was covered in small, brown spots.</p> <p>Interview on 11/12/24 at 8:55 A.M. with Lead Receptionist #146 confirmed the nebulizer was covered in small, brown spots and placed on the floor while plugged in. Receptionist #146 stated the nebulizer should not have been on the floor, but at times, Resident #42 would move it. Receptionist #146 also stated the nebulizer needed to be cleaned.</p> <p>Review of a policy titled, Respiratory Therapy- Prevention of Infection, dated November 2019, revealed it was the facility's policy to prevent infection associated with respiratory therapy tasks and equipment among residents and staff. After the completion of nebulizer therapy, the nebulizer container should be removed, rinsed with fresh tap water, and dried with a clean paper towel or gauze sponge. The nebulizer should be reconnected to the administration set-up, the mouthpiece should be wiped with a damp paper towel or gauze sponge, then stored in a plastic bag, marked with the date and the resident's name.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Altercare Thornville Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 14100 Zion Road Thornville, OH 43076	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50008</p> <p>Based on observations, interview, and facility policy, the facility failed to ensure the ice machine was maintained in a sanitary manner. This had the potential to affect all 49 of the residents residing in the facility. The facility identified all 49 residents in the facility as receiving iced beverages from the main kitchen ice machine.</p> <p>Findings include:</p> <p>On 11/12/24 at 8:52 A.M. an observation revealed that the inside of the ice machine in the main kitchen had a red slimy substance next to the prepared ice. On the inside of the ice machine, on the right top near the cooling mechanism, a white crusty build-up was observed.</p> <p>An interview with Dietary Director #163 on 11/12/24 at 8:52 A.M. confirmed the presence of the red slimy substance next to the prepared ice and the white crusty build-up on the right side of the ice machine, near the cooling mechanism.</p> <p>An interview with the Assistant Director of Dietary Services #305 on 11/12/24 at 10:27 A.M. revealed that the ice machine was deep cleaned by an outside company that serviced the machine. The Assistant Director of Dietary Services #305 stated that he had obtained bagged prepared ice for the residents to use for the day.</p> <p>An observation on 11/13/24 at 10:41 A.M. revealed that the red slimy substance had been removed from the ice machine. The white crusty build-up was still observed on the inside of the ice machine on the top right side, near the cooling mechanism.</p> <p>An interview on 11/13/24 at 10:41 A.M. with Assistant Director of Dietary Services #305 confirmed the presence of the white crusty build-up was still on the right side of the inside of the ice machine. On 11/13/24 at 11:50 A.M. the Assistant Director of Dietary Services #305 stated that a company had been called to de-lime the ice machine.</p> <p>A facility policy titled, Ice Machine, dated October 2020, revealed that the ice machines shall be free of rust, lime and mildew at all times.</p>