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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Thornville Inc.	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)
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, record review, and interview, the facility failed to ensure a resident was shaved per preference upon admission to the facility and during first shower. This affected one resident (#54) of two residents reviewed for activities of daily living. The facility census was 48. Findings include:Record review revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including other displaced dens fracture, muscle weakness, and hemiplegia. Review of an order dated 02/15/26 revealed Resident #54 required extensive assistance for bathing and limited assistance for personal hygiene and shaving. Review of a shower sheet revealed Resident #54 received a shower on 02/16/26. Observation on 02/17/26 at 2:35 P.M. revealed Resident #54 was sitting in bed with non-skid socks on, a hospital gown, and his hair was disheveled. Resident #54's facial hair was long and unkempt. Interview on 02/17/26 at 2:35 P.M. with Resident #54 revealed he would like to be shaved, but he did receive a shower though he couldn't remember when. Interview on 02/17/26 at 2:54 P.M. with Certified Nursing Assistant (CNA) #104 revealed Resident #54 was new to her. She got to her shift at 2:00 P.M. and had not cleaned him up. CNA #104 confirmed Resident #54 was wearing a hospital gown, had disheveled hair and his facial hair was grown and needed trimmed. Observation on 02/18/26 at 8:51 A.M. revealed Social Worker (SW) #131 coming out of Resident #54's room stating to a coworker, you should have seen how happy he was when I shaved him yesterday. Interview on 02/18/26 at 9:18 A.M. with Resident #54 revealed he got shaved yesterday and felt much better. Interview on 02/18/26 at 2:05 P.M. with CNA #117 revealed if a new admission came in who had disheveled hair and unkempt facial hair, she would be able to provide hygiene care as soon as the nurse finished with the admission process. CNA #117 confirmed there was plenty of time from Resident #54's admission to 02/17/26 for him to have been shaved. Review of a policy dated 01/2018 titled Shaving a Resident revealed the facility should promote resident hygiene by assisting a resident with removal of facial hair as needed.

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	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 observation, staff, visitor and resident interview, review of the medical record and policy review, facility failed to ensure a newly identified skin impairment was assessed timely. This affected one resident (#9) of three residents reviewed for wounds. The facility also failed to ensure a change in condition was addressed timely. This affected one resident (#25) of one resident reviewed for change in condition. Facility census was 48. Findings include 1. Review of the medical record for Resident #9 revealed an admission date of 08/25/25. Diagnoses included heart failure, muscle weakness, altered mental status, and diabetes. Review of the plan of care dated 08/25/25 revealed the resident was at risk for skin breakdown with interventions to report signs and symptoms of skin irritation including irritation and report to the physician. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition and required assistance with activities of daily living. Review of physician orders dated 02/15/26 to pad and protect bunion on right foot for preventative every three days until healed and order dated 02/15/26 to remove boot on right foot while resident is in bed and float heal to prevent skin conditions at bedtime. Review progress notes dated 02/15/26 revealed new area found on resident's right foot, pad and protect every three days for preventative all parties aware. Review of wound assessments from 02/01/26 to 02/19/25 revealed no wound assessment was completed. Review of wound reports from 02/01/26 to 02/19/26 revealed no wound report was done. Interview and observation on 02/17/26 at 9:58 A.M. with Resident #9 revealed the resident had a medical boot on his right foot and stated it was due to having surgery on his heel and an amputation of a toe. He reported staff recently told him he had a new open wound on his right foot and placed a bandage over it. He was unsure what type of wound he had, but stated it was from his boot rubbing on his foot. Observation and interview on 02/19/26 at 9:00 A.M. with Assistant Director of Nursing (ADON) #163 removed the boot and observed resident skin on his right foot. Resident had a bandage over the inside of the foot at the sesamoid bone joint. The bandage was removed and identified a red area about the size of a nickel on the boney prominence of the foot. The area did not appear to be open and did not have drainage. The ADON stated she was not aware of the skin impairment as she had been off for the past few days and stated it was from sheering and friction from the boot. She reported the ADON stated it was from sheering and friction of the boot. The ADON confirmed it was documented in the progress note as a new area and in the order as a bunion and she stated she did not believe it was pressure as the foot was not pressing on the boot and was rubbing and sheering skin from the boot. The ADON confirmed the facility did not have a completed assessment or description of the skin impairment and stated she would assess it this date (02/19/26) and reported she had a week to complete the wound/skin impairment assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/19/26 at 9:30 A.M. with ADON revealed she did a full assessment of the wound and stated it was non-blanchable. She stated she would contact the medical provider and verify what orders they wanted for treatment and preventative care. She confirmed this would not be classified as a pressure wound. Interview on 02/19/26 at 10:14 A.M. with Director of Nursing (DON) revealed she would expect the nursing staff to assess a new skin impairment/wound and document the assessment on the shift it was identified, including pressure and non pressure wounds. The DON confirmed the assessment should give a description of the wound including size, location, redness, drainage etc. Review of policy titled Skin assessment dated [DATE] revealed facility shall assess and implement interventions to promote skin integrity. Review of policy titled Wound Prevention dated 05/01/25 revealed inspection of skin for signs and symptoms of breakdown or pressure should be conducted by direct care. Whenever possible avoid friction and shearing when caring for a residents including providing padding for casts splints and braces and check for redness. 2.Record review revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including dementia, muscle weakness, and edema. Review of a care plan dated 11/14/23 revealed Resident #25 had impaired ability to perform or participate in daily activity of daily living (ADL) care related to dementia, muscle weakness, depression, chronic kidney disease, polyneuropathy, osteoarthritis, dizziness and giddiness, and history of peripheral vascular disease. The goal was for Resident #25 to participate with ADLs as much as possible and to remain clean, dry, comfortable, and neat in appearance by the target date as well as maintaining current level of ADLs without decline by target date. Interventions included but were not limited to assist with toileting if needed; provide incontinence are as needed; observe/report any decline in ADLs, mobility or cognition; provide assistance with all ADL care and mobility as needed/anticipate resident needs as able and encourage resident to participate with care as tolerated- refer to resident profile for ADL assistance needed; and refer to physical therapy (PT), occupational therapy (OT), speech therapy (ST) of restorative nursing as needed. Review of a care plan dated 11/14/24 revealed Resident #25 was occasionally incontinence of bladder and was at risk for altered dignity, skin breakdown and urinary tract infections. The goal was for Resident #25 to not have alteration in dignity related to urinary incontinence by the target date and to not develop complications related to urinary incontinence such as skin breakdown or urinary tract infections. Interventions included but were not limited to assess quarterly and as needed for any change in elimination patterns; maintain resident dignity when checking/providing incontinence care; and refer to restorative book for toileting program and toileting times if applicable. Review of care plan dated 11/27/23 revealed Resident #25 had impaired cognition, dementia, short-term memory loss, disorientation to time, and a brief interview for mental status (BIMs) score below 13. The goal was for Resident #25 to function at optimum level within limitations. Interventions included but were not limited to administer medication as ordered; introduce self, use calm approach and explain all procedures prior to beginning; and observe and report any changes in mental status or behaviors to physician and keep resident representative informed of resident's status. Review of an MDS dated [DATE] revealed Resident #25 was occasionally incontinent, had moderately (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired cognition, and required supervision to touching assistance for transfers. Review of a care plan dated 01/07/26 revealed Resident #25 had urinary incontinence per tracking/assessment and is a candidate for prompted toileting program. The goal was to reduce incontinence episodes to less than daily by next review date. Interventions included but were no limited to assist/remind resident to wipe after toileting and wash hands to promote hygiene; change clothing/incontinence pads/briefs/linen as needed due to soiling from bladder incontinence and provide incontinence care as needed; explain program to resident as about before beginning and give positive feedback and praise resident for participating in the program; prompt and remind resident for toileting program; provide physical support/assistance for toileting safety as indicated for resident; and review toileting times and program progress quarterly. Review of orders dated 01/21/26 revealed Resident #25 was occasionally incontinent of bladder and always continent of bowel; and required supervision to touching assistance for transfers. Review of bladder function documentation from 01/22/26 through 02/05/26 revealed Resident #25 was incontinent of urine 16 times and was continent of bladder 34 times. Review of a nursing note dated 02/05/26 at 8:43 A.M. by Director of Nursing (DON) revealed new orders were received from Nurse Practitioner (NP) #305 for Resident #25 to have Lasix 20 milligrams (mg) by mouth every afternoon for seven days for lower extremity edema; daily weights for seven days; and a complete blood count/basic metabolic panel on 02/11/26. All parties were made aware. Review of bladder function documentation from 02/06/26 through 02/09/26 revealed Resident #25 was incontinent of urine eight times and continent of bladder five times. Review of a nursing note dated 02/09/26 at 2:50 P.M. by the DON revealed Physician #306 revealed urinary analysis results for Resident #25 with no culture indicated. Review of a provider note dated 02/10/26 by Nurse Practitioner (NP) #305 revealed Resident #25 was being seen for a follow-up visit for chronic conditions including atrial fibrillation, hypertension, and dementia. NP #305 documented no new concerns and no new staff concerns. Review of bladder function documentation from 02/10/26 through 02/12/26 revealed resident #25 was incontinent of bladder six times and continent of bladder six times. Review of a provider note dated 02/12/26 by NP #305 revealed Resident #25 was being seen as a follow up for chronic conditions including anemia, chronic kidney disease and osteoarthritis. NP #305 documented no new staff concerns. Review of a nursing note dated 02/12/26 at 9:39 A.M. by the DON revealed labs were reviewed by NP #305 and all parties were aware. Review of bladder function documentation from 02/13/26 through 02/18/26 revealed Resident #25 was incontinent of bladder 11 times and continent of bladder seven times. Interview on 02/17/26 at 10:00 A.M. with Resident #25 revealed she was confused. Resident #25 had a visitor at the time who was not a representative but stated Resident #25 was off since going home last week and had increased confusion. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/18/26 at 2:07 P.M. with Certified Nursing Assistant (CNA) #117 revealed Resident #25 had increased confusion starting on either 02/11/26 or 02/12/26 and thought she was just declining related to her health. Interview on 02/18/26 at 3:16 P.M. with Registered Nurse (RN) #116 revealed a urinalysis was completed on Resident #25 which was negative but there was no additional information in the chart about a change in condition. Interview on 02/19/26 at 8:20 A.M. with Licensed Practical Nurse (LPN) #151 revealed a urinalysis (UA) was completed on Resident #25 because her back had been hurting but the UA was negative. LPN #151 stated she did not have increased confusion and she was at her baseline. Interview on 02/19/26 at 8:43 A.M. with CNA #118 revealed Resident #25 had a change in the last couple weeks. She had a UA completed then went to her family's house for her birthday and was still having a change including being incontinent when she used to get up by herself. CNA #118 stated Resident #25 was now a check and change for the bladder program and she has needed more assistance getting out of bed. Resident #25 was previously supervision to touching assistance for transfers but was requiring a minimum assistance of one staff more often. CNA #118 stated when she identifies a change in condition she notifies the nurse. CNA #118 stated she notified LPN #151 on 02/13/26 of Resident #25's decline. Interview on 02/19/26 at 8:52 A.M. with CNA #134 revealed due to not working as much, she has noticed small changes in Resident #25 including being more forgetful and now requiring a one-staff assist when before she could transfer with supervision. CNA #134 stated she felt the change occurred a few weeks ago. CNA #134 stated Resident #125 is always continent of bowel, but it is hit or miss with bladder. CNA #134 stated she had not reported a change in condition because she figured another staff had likely already reported the change in condition. Observation on 02/19/26 at 9:10 A.M. revealed LPN #151 on the phone and stated, we did the urine on Resident #25 and it was negative but now she is incontinent, what do you want to do? When LPN #151 got off the phone, she stated we are ordering a UA for Resident #25. Review of a nursing note dated 02/19/26 at 9:10 A.M. by LPN #151 revealed she spoke with a provider regarding Resident #25 due to incontinence and a new order was received from NP #305 for a urinalysis and a culture/sensitivity. Interview on 02/19/26 at 9:31 A.M. with CNA #104 revealed Resident #25 had a change at the end of last month (January) because her back started hurting more, she needed more assistance with stand-pivot transfers minimum assist of one when she was supervision before. CNA #104 stated sometimes Resident #25 could still transfer but she would hit the call light to ask for help when needed. CNA #104 stated Resident #25 used to be incontinent every once in a while, but now she is always incontinent to the point she is soaking the bed. CNA #104 stated Resident #25 has gotten more confused because sometimes she would come out of her room asking where she was, who the staff are, and how do they know her. CNA #104 stated the increased confusion started last month but continued to progress. Interview on 02/19/26 at 9:57 A.M. with the DON revealed she did not consider Resident #25's decline to be a change in condition because the incontinence is not new, she had a brief increase in Lasix so that could contribute to the increase incontinence, and her Aricept (medication to slow progression of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia) so a decline was anticipated. The DON stated to speak with staff who work with Resident #25 daily because they will confirm it isn't a change. Interview on 02/19/26 at 12:53 P.M. with DON revealed she still did not consider Resident #25's decline a change in condition and the staff spoken with during the survey were too close to the resident so it was personal to them but there was not actually a change. The DON stated Resident #25 had therapy in December (2025) but declined to continue. The DON confirmed therapy had not been offered again since the decline because she had refused previously. The DON did not provide any additional evidence to show a complete, thorough assessment of the resident from a nurse or the provider or any documentation to address the change in condition. Review of a policy dated 05/01/25 titled Change in the Residents Condition or Status revealed it is the facility's policy to ensure the resident's attending physician and authorized representative or interested family member are notified of a change in condition including physical, mental, or psychosocial status. A significant change in condition will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacts more than one area of the resident's health status, and requires interdisciplinary review and/or revision to the plan of care. The nurse should record in the medical record information relative to changes in the resident's medical/mental condition or status.

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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 record review, observation, interview, and policy review, the facility failed to ensure a resident at risk for pressure ulcers had pressure ulcer prevention interventions implemented as per their plan of care. This affected one resident (#2) of three residents reviewed for pressure ulcers. Findings include:Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, heart failure, chronic kidney disease, hypotension, restless leg syndrome, anemia, and muscle weakness. Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was moderately impaired. No behaviors or rejection of care was noted. He required supervision/ touching assistance with bed mobility and was identified as being at risk for pressure ulcers. Review of Resident #2's care plans revealed the resident had an active care plan in place for being at risk for skin breakdown related to impaired cognition, anemia, liver disease, renal disease, and abnormal weight loss. The care plan originated on 10/02/24. The goal was for the resident to not develop skin breakdown daily by the next review date. The interventions included encouraging/ assisting the resident to float heels as tolerated. That intervention was added on 10/16/24. On 02/18/26 at 9:56 A.M., an observation of Resident #2 noted him to be lying in bed in a supine position with his eyes open. His heels were in direct contact with his mattress and not floated/ offloaded as per his plan of care. On 02/18/26 at 11:13 A.M., an interview with Certified Nursing Assistant (CNA) #109 revealed she did not consider Resident #2 to be at risk for pressure ulcers. She was asked what interventions were in place to help prevent the resident from getting pressure ulcers. She indicated, if they noted the resident was staying in bed too much and not getting up, they would go in and encourage him to get out of bed. She did not mention anything about the need to keep his heels floated when in bed. She was asked to accompany the surveyor to the resident's room to see if he had anything under his heels to help offload them. She pulled his blanket back and confirmed his heels were in direct contact with the mattress and not floated, as per his plan of care. Review of the facility's policy on Pressure Injuries: Assessment, Prevention, and Treatment updated 05/01/25 revealed it was 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. Interventions and preventative measures were to be provided, as indicated, based on resident risk factors.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review the facility failed to implement a fall risk intervention for a resident after a fall. This affected one resident (#4) of one resident reviewed for falls. The facility census was 48.Findings include:Review of Resident #4's medical record revealed the resident was admitted on [DATE] and had diagnoses that included dementia, muscle weakness, cognitive communication deficit, cardiac arrhythmia, peripheral vascular disease, and neuropathy. Review of the Brief Interview for Mental Status dated 12/25/25 revealed a score of 09, which indicates moderately impaired cognition. Review of fall risk assessment dated [DATE] revealed the resident had a fall risk score of 18, which indicated a high fall risk. Observation on 02/19/26 at 8:30 A.M. revealed no non-skid strips in Resident #4's room. Review of fall without injury event report dated 01/06/26 revealed Resident #4 had an unwitnessed fall on 01/06/26. Further review of the investigation report revealed the immediate safety measures that needed to be implemented due to the circumstances of the fall were non-skid strips. Interview on 02/19/26 at 8:39 A.M. with the Director of Nursing (DON) stated that she was on the unit when Resident #4's fall happened on 01/06/26. She stated that based on the fall investigation report, the facility should have added non-skid strips to Resident #4's floor near her bed. The DON confirmed that non-skid strips were not present in the room at the time of the interview. The DON confirmed there was no documentation that this intervention was in place. Review of the facility's policy titled Fall Risk Management, dated 05/01/25, revealed it is the facility's policy to conduct a root cause analysis post fall to assist the interdisciplinary team in updating the resident's plan of care with the interventions to reduce the risk of recurrent falls.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident receiving medication for hypotension did not receive the medications when his systolic blood pressure (SBP) was greater than 130 millimeters per mercury (mmHg), as per parameters included in his physician's orders. This affected one resident (#2) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included heart failure, atrial fibrillation, and hypotension (low blood pressure). Review of Resident #2's physician's orders revealed the resident had an order to receive Midodrine (a medication used to treat symptomatic orthostatic hypotension by tightening blood vessels to raise blood pressure) 2.5 milligrams (mg) twice a day. Parameters were included with directions to hold the medication when the resident's SBP was greater than 130 mmHg. The order originated on 01/27/26. Review of Resident #2's electronic medication administration record (eMAR) for January 2026 revealed the resident's Midodrine 2.5 mg that was ordered twice a day was scheduled to be given at 7:00 A.M. and 2:00 P.M. The MAR also included documentation of what the resident's blood pressure was before the administration of the medication. There were five times in January 2026, where the resident's SBP was recorded as having been greater than 130 mmHg, and it was documented that the medication was administered. On 01/27/26 at 2:00 P.M., the resident's SBP was 133 mmHg; on 01/28/26 at 7:00 A.M., the resident's SBP was recorded as being 132 mmHg; on 01/29/26 at 2:00 P.M., the resident's SBP was recorded as being 134 mmHg; on 01/30/26 at 7:00 A.M., the resident's SBP was recorded as being 137 mmHg; and on 01/30/26 at 2:00 P.M., the resident's SBP was recorded as being 135 mm/Hg. All five times, the nurses initialed the eMAR to reflect the Midodrine had been administered, and was not held as per the parameters included with the order. Review of Resident #2's eMAR for February 2026 revealed the resident was administered Midodrine 2.5 mg on 02/16/26 at 2:00 P.M., when his SBP was recorded as having been 133 mm/Hg prior to the medication being given. The nurse initialed the eMAR to reflect the medication was given and was not held per the parameters set in the order. On 02/18/26 at 3:15 P.M., an interview with the facility's Director of Nursing (DON) confirmed Resident #2's physician's orders did include parameters on when to hold the resident's Midodrine used for the treatment of hypotension. She verified the current physician's order was to hold the Midodrine, when the resident's SBP was greater than 130 mmHg. She acknowledged there were six times, since the order had been given, that the resident received Midodrine 2.5 mg, where the medication should have been held per the parameters included in his physician's orders.