

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Adams Lane Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1856 Adams Lane Zanesville, OH 43701	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and facility policy and procedure review, the facility failed to maintain a clean and homelike environment. This was observed in four units (100, 200, 300 and 700) of seven units in the facility and affected five residents (#26, #33, #85, #97, and #107) of 107 residents reviewed for their environment. The census was 107. Findings include: 1. Observation on 06/03/26 at 12:50 P.M. revealed in room [ROOM NUMBER] the baseboard by the closet was coming loose, and area on the ceiling by the closet patched and stained a light colored brown. This was verified during interview with Maintenance Director #228 on 06/03/26 at 12:55 P.M. 2. Observation on 06/03/26 at 12:56 P.M. revealed in room [ROOM NUMBER] paint scuffed off the wall in multiple places. This was verified during interview with Maintenance Director #228 on 06/03/26 at 12:56 P.M. 3. Observation on 06/03/26 at 12:57 P.M. revealed in room [ROOM NUMBER] paint was scuffed off the walls in multiple places. This was verified during interview with Maintenance Director #228 on 06/03/26 at 12:57 P.M. 4. Observation on 06/01/26 at 10:13 A.M. revealed at the end of the 700 hallway a lounge area with a television mounted on the wall, table and chairs, a couple recliner chairs and a small couch. On the other side of the room were two bed frames, an electric wheelchair and several manual wheelchairs. There were no residents in the lounge area. Interview on 06/01/26 at 11:03 A.M. with housekeeping staff (HSK) #246 verified the two bed frames, the electric wheelchair and several manual wheelchairs. HSK #246 stated the equipment had been in the lounge area for several weeks, residents used to use the lounge area, but don't come to the lounge area anymore and activities does not use the lounge area either. The equipment used to be stored in the storage room, which was now being used as an office. Interview on 06/02/26 at 10:10 A.M. with the Administrator stated the facility did not have a policy for equipment storage for review. 5. Review of Resident #85's medical record revealed an admission date of 10/23/23 and diagnoses including cerebral palsy, severe intellectual disabilities, dysphagia, gastrostomy status, unspecified convulsions, and other muscle spasm. Review of Resident #85's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was unable to complete the brief interview for mental status due to rarely/never understood (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and had severe cognitive impairment. Further review of the MDS revealed Resident #85 was dependent on staff for all activities of daily living, was always incontinent of bladder and bowel and received nutrition via enteral feeding. An observation on 06/03/26 at 11:00 A.M. revealed Resident #85's floor to have an unknown black substance ground into the tile in front of the free standing closet in a random scattered pattern and a chipped/broken area of tile in front of the right side of the free standing closet. An observation on 06/03/26 at 1:26 P.M. with the Maintenance Director revealed Resident #85's floor to have an unknown black substance ground into the tile in front of the free standing closet in a random scattered pattern and a chipped/broken area of tile in front of the right side of the free standing closet. In an interview at the same time the Maintenance Director verified Resident #85's floor to have an unknown black substance ground into the tile in front of the free standing closet in a random scattered pattern and a chipped/broken area of tile in front of the right side of the free standing closet. Review of the policy titled Housekeeping Policy revised 06/2023 revealed resident's room floors are to be clear of spills, stains and derbies. 6. Observations on 06/01/26 at 2:08 P.M. revealed Resident #33 was up a customized chair. The foot rest of the chair was completely covered with strips of black tape with the resident's feet resting on the tape. Observations on 06/03/26 at 1:00 P.M. revealed the black strips of tape remained on the foot of the customized chair. This was confirmed during interview of the Director of Nursing at the time of the observation. 7. Observations on 06/02/26 at 9:02 A.M. revealed the floor in Resident #97's room was dirty with a heavy build up of dirt around the parameter of the room, especially near the bathroom door and around the edges of the dressers in the room. There was a white material splattered on the bottom of a black dresser in the room. Resident #97 stated, at that time, that the facility does not do any deep cleaning of the room including moving furniture to clean under it. Observation on 06/03/26 at 1:30 P.M. revealed the dirty floor and dirty dresser was confirmed by the Director of Nursing. 8. Observations on 06/02/26 at 10:53 A.M. revealed the floor in Resident #26's room was dirty with a heavy build up of dirt around the parameter of the room, especially near the bathroom. Observations on 06/03/26 at 1:32 P.M. revealed the dirty floor was confirmed by the Director of Nursing. 9. Observations on 06/02/26 at 7:49 A.M. revealed the bathroom sink (used by Resident #107) in the bathroom connected to room [ROOM NUMBER] was cracked in the basin making it an uncleanable surface. The sink faucet was corroded where the water came out. The mirror in the bathroom had a film over it making it difficult to see in. These observations were confirmed by the Director of Nursing on 06/03/26 at 1:33 P.M. This deficiency represents non-compliance investigated under Complaint Number 2982079.		