STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366244	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Willow Haven	1020 Taylor Street 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. 28704 Based on observation, maintenance log review, weather history review, policy review and interview, the facility failed to maintain a comfortable and safe living environment. This affected five residents (#105, #108, #110, #111, and #114) in the facility. The census was 71. Findings include: 1. Review of the electronic 2024 AccuWeather History for June 2024 revealed the following air temperatures for Zanesville, Ohio between 06/17/24 and 06/22/24 during the excessive heat advisory that was issued. The below temperatures did not include humidity which had effects on the real feel temperature: On 06/17/24, 95 degrees (F). On 06/18/24, 93 degrees (F). On 06/19/24, 87 degrees (F). On 06/20/24, 92 degrees (F). On 06/21/24, 94 degrees (F). On 06/22/24, 94 degrees (F). Review of the facility Air Temperature Logbook Documentation dated 06/20/24 revealed the following temperatures: Hall 100, 74 degrees (F) Hall 200, 75 degrees (F) Hall 300, 72 degrees (F) Hall 400, 72 degrees (F) (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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(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	Hall 500, 75 degrees (F). The resident rooms all had individual AC units that were functioning. On 06/24/24 from 8:06 A.M. to 8:20 A.M., observation revealed large portable air conditioning units were being utilized on each hallway with dual vent coils extending up to the ceiling. Fans were observed sitting on the floor in the hallways including three freestanding 22 inch metal fans, one 25 inch high velocity fan, one box fan and two standup cylinder fans. Interview with Environmental Services Director (ESD) #5 at the time of the observation revealed the facility's main air conditioning (AC) units were not working properly, portable AC units were purchased last week and installed over the weekend to cool the facility common areas. ESD #5 verified the fans in the hallways were to keep the air circulating. Interview on 06/24/24 at 8:55 A.M., interview with Maintenance Supervisor #66 revealed the AC unit on both the 200 and 500 halls had not worked since last year and now none of the AC units were working. The facility had been using fans roughly for three weeks in an attempt to keep air circulating and keep it cool. The 100 hall AC unit was recharged with coolant but it did not last but a couple hours and then it quit again. Corporate had been working on ordering new units for the 100, 200 and 500 halls but in the meantime the facility purchased portable AC units on 06/20/24 and he installed the units on 06/22/24. Maintenance Supervisor #66 stated he checks air temperatures weekly but since the excessive heat, he had been checking the hall temperature daily but did not document these temperatures. He stated the common area temperatures including the hallways did not exceed 81 degrees (F) but he had no documentation of this. Interviews on 06/24/24 between 10:20 A.M. and 10:35 A.M. with Resident #108 and #111 revealed the facility temperatures outside of their rooms were uncomfortable last week, they did not know the exact temperature but it was hot stating the AC units were broken. Resident #108 stated she spoke to the Administrator twice about the hot temperatures in the hallway and was concerned for the staff working environment. Resident #108 and #111 stated since installing the portable AC units, temperatures outside of their rooms were now comfortable again. Interviews on 06/24/24 between 12:32 P.M. and 1:01 P.M. with Resident #110 at 12:32 P.M. revealed the facility AC units were not functioning last week and it was difficult for her to breath due to her asthma. Resident #110 stated she had to stay in her room most of the time last week because it was 'too hot' in the hallways and common areas making it difficult to breathe. Resident #114 stated the facility temperature was comfortable now but it was hot last week. On 06/24/24 at 2:30 P.M., interview with Resident #105 stated the facility AC units were not functioning and the hallways were hot until they installed the portable AC units but no residents had voiced complaints to her about it. On 06/24/24 interviews with the following staff verified the facility AC units had not been working properly during the excessive heat warnings between 06/17/24 and 06/22/24 resulting in the facility common areas being hotter than normal: at 8:06 A.M. with Admission Director #17, at 8:13 A.M. with ESD #5, at 8:54 A.M. with Maintenance Supervisor #66, at 9:54 A.M. with State tested Nurse Aide #57, at 1:47 P.M. with Licensed Practical Nurse, at 2:38 P.M. with both the Director of Nursing and the Assistant Director of Nursing, and at 2:55 P.M. with Laundry #92. (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy: Temperature Extremes (dated June 2019) revealed the facility was to provide comfortable and safe temperature levels. Should the AC system fail, specific monitoring and safety measures should be activated and additional responses included maintaining a log of temperature monitoring. 2. On 06/24/24 at 8:54 A.M. and 9:22 A.M., observation of 100 hall shower room with Maintenance Supervisor #66 revealed the drywall was torn off the wall exposing water pipes leading to the shower head. Broken pieces of drywall, ceramic tile and tile grout was observed to be covered with black/gray speckled mold on the floor and shower stall tiles. At the time of the observation, Maintenance Supervisor #66 verified there was mold in the shower area and had was not notified of this. Maintenance Supervisor #66 verified the shower had a small leak when he first came in October 2023 and when they removed the drywall to fix the leak it was bigger than they thought and discovered that there was a leak inside the wall. Maintenance Supervisor #66 stated it was unknown if this area including area behind the intact drywall had been tested for the presence of black mold. He stated all the drywall in the shower area was going to be removed and replaced because it was not waterproof and that is how the mold probably developed. Maintenance Supervisor #66 stated the shower room was supposed to have a sign on the outside of the door indicating this room was not to be used; however, it did not have a sign. Equipment stored in the shower room included a sit-to-stand lift, hoyer lift, shower chair and a bariatric wheelchair ready for use. On 06/24/24 at 9:17 A.M., interview with Regional Administrator #93 verified the presence of mold that was black/gray colored on broken pieces of drywall, ceramic tiles and grout in the shower stall in the 100 hall shower room. Regional Administrator #93 verified this area had not been tested and did not know if it was black mold or not. Regional Administrator #93 stated she was instructing staff to clean-up the area. On 06/24/24 at 9:54 A.M., interview with State tested Nurse Aide #57 stated staff did not use the 100 hall shower room because it was broke. Any resident can go to any available shower room on the 200, 400 or 500 halls to shower as it just depends which shower room is available. State tested Nurse Aide #57 stated the 300 hall did not have a shower room. On 06/24/24 between 2:50 P.M. and 3:00 P.M., observation of the 200 hall shower room revealed Laundry #92 was coming out of the shower room holding the upper portion of her shirt over her mouth and nose and was coughing. A very strong bleach smell was coming from the shower room that made your eyes water. The door was closed at that time. Interview with Laundry #92 stated she was instructed to use the bleach in the 200 hall shower room to remove the mold from the shower stall. Observation of the 200 hall shower room revealed a continued strong smell of bleach and black mold was observed on the large and small ceramic tiles and grout in the shower room even in the areas that had been scrubbed with a brush and bleach per Laundry #92. Interview with the Administrator at the time of the observation verified the presence of mold and that she was not aware of this. The Administrator stated residents did use this shower room. Interview with ESD #5 on 06/24/24 at 3:00 P.M. stated she instructed Laundry #92 to clean the shower stall with bleach to remove the mold after she was told about it by the Director of Nursing and Assistant Director of Nursing. Review of the Maintenance Logs dated May and June 2024 revealed no evidence staff reported/documented AC unit failure or mold in the 100 and 200 hall shower rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Master Complaint Number OH00155048 and Complaint Number OH00155031.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 28704 Based on observation, policy review and interview, the facility failed to maintain a safe and hazard free environment. This had affected 14 residents (#101, #109, #114, #115, #117, #119, #125, #130, #138, #140, #156, #164, #166 and #171) identified by the facility as cognitively impaired and independent with mobility. The census was 71. Findings include: On 06/24/24 from 8:06 A.M. to 8:20 A.M., observation revealed large portable air conditioning units were being utilized on each hallway with dual vent coils extending up to the ceiling. Fans were observed sitting on the floor in the hallways including three freestanding 22 inch metal fans, one 25 inch high velocity fan, one box fan and two standup cylinder fans. Interview with Environmental Services Director (ESD) #5 at the time of the observation revealed the facility's main air conditioning (AC) units were not working, the fans in the hallways were to keep the air circulating and residents had unrestricted access to the fan blades through the slats on the fan cover. Interview on 06/24/24 at 8:55 A.M., with Maintenance Supervisor #66 revealed none of the AC units were working in the facility and they had been using fans for roughly three weeks in an attempt to keep air circulating and keep it cool. Observation on 06/24/24 at 9:07 A.M., during a follow-up tour of the facility, the Administrator verified the fans on the hallways posed an accident hazard due to the slats on the fan cover were big enough to stick objects (including fingers) into the fan, the cords were laying out into the hallway unsecured, and the AC unit and fans were positioned on both sides of the unit hallways along with wheelchairs, medication carts and other care equipment blocking access to the handrails. Also two fan plugs were partially hanging out of the outlet and were not securely plugged in. The Administrator verified the above was a potential hazard to cognitively impaired residents who were independently mobile. Observation on 06/24/24 at 10:35 A.M. revealed all the fans were removed from the hallways except two stand-up cylinder type fans. Interview with Maintenance Supervisor #66 at the time of the observation verified the fans were placed into a storage room on the 200 hall due to the fan cover slats were large enough to stick items in between them posing a hazard. On 06/24/24 at 2:40 P.M., interview with the Administrator stated the facility did not have a policy regarding accident hazards. The facility identified 14 residents 14 residents as cognitively impaired and independent with mobility (#101, #109, #114, #115, #117, #119, #125, #130, #138, #140, #156, #164, #166 and #171) . This deficiency represents non-compliance investigated under Complaint Number OH00155031.