Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Willow Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - 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** 28923 Based on record review, review of the facility's timeline and related investigation, review of staff education records, resident interview, staff interview, and policy review, the facility failed to ensure nursing staff were adequately trained and knowledgeable on the use of Negative-Pressure Wound Therapy (NPWT) (wound vac) and were able to maintain, monitor, and intervene appropriately when complications arose. They also failed to implement a physician's order to obtain a CT scan and refer a resident to a surgeon when he showed signs of an infected abdominal wound. This affected one resident (#10) of one resident reviewed for wound vac therapy management. Harm occurred on 07/03/24 for Resident #10, who had a history of abdominal wall infections, when he displayed possible signs of infection in an abdominal wound, and the wound physician ordered a CT scan of his abdomen and a referral back to his surgeon. The facility failed to make the referrals as ordered. Resident #10 had complications related to the use of a wound vac and a facility nurse failed to adequately intervene or notify the wound physician of the complications they were having with his wound vac. His wound vac began to leak the evening of 07/07/24 and the wound drainage progressively increased through the night saturating draining from his abdominal wound. By morning, the area around his abdominal wound became red, hard, and warm to touch with complaints of mild to severe abdominal pain. Resident #10 was transferred to the hospital and hospitalized between 07/08/24 and 07/17/24 requiring two separate incisions and drainage to debride the abdominal abscess and to remove a foreign body. Findings include: Review of Resident #10's medical record revealed he was admitted to the facility with an initial admitted [DATE]. His diagnoses included a cutaneous abscess of the abdominal wall, sepsis, gastrostomy malfunction, morbid obesity, and an infection due to a bariatric procedure. Review of Resident #10's physician's orders revealed he had an order in place to maintain NPWT to the left flank at 125 mmHg continuous with the need to check the placement and function every shift. The order had been in place since 06/19/24. He also had an order to change the NPWT dressing to the left flank every Monday, Wednesday, and Friday. That order had been in place since 06/19/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #10's wound visit note dated 07/03/24 revealed he was seen by Wound Physician #100 on 07/03/24 as a routine weekly visit. The wound physician assessed the resident's non-healing surgical wound of the left flank and indicated it had a large amount of exudate coming from the wound. His treatment order continued to include the implementation of NPWT every Monday, Wednesday, and Friday, while applying 125 mmHg on a continuous basis. Under the comments, the wound physician indicated only one piece of white foam was to be used. The comments also indicated the output of the wound vac had increased. He requested that the facility please get a CT scan of the abdomen to evaluate for an abscess at the left flank. He also wanted them to re-consult surgery regarding the left flank wound due to increased drainage. The order for both the CT scan and the re-consult with surgery order had been written on 07/03/24 at 5:01 P.M. Resident #10's medical record was absent for any evidence of the CT scan being ordered/ scheduled or that the surgeon had been contacted for a re-consult as was ordered by the wound physician. Review of Resident #10's nurses' progress notes revealed a nurse's note by Licensed Practical Nurse (LPN) #120 dated 07/08/24 at 10:29 A.M. that indicated the nurse went in to change the resident's wound vac and his wound vac was noted to be turned off and not intact. The resident was observed by the nurse to be lying in a puddle of drainage. When the nurse assessed the resident's left flank, it was noted to be very swollen, red, and warm to touch. The resident stated he had mild to severe pain to the surrounding area. Physician #135 was in the building and gave an order to send the resident to the emergency room (ER) for further evaluation. Review of a Discharge Summary note by Physician #135 revealed Resident #10 was discharged to the ER for an abdominal wall abscess. He had a history of a PEG tube dislodgement with necrotizing fasciitis, abscess of abdominal wall, and severe sepsis. The history of the present illness indicated the resident had a marked increase in abdominal wall edema and he was discontinued from the use of the wound vac. The wound of his abdomen was a non healing abdominal wound. Evidence of recurrence. Management was beyond the scope of the skilled nursing facility and would need imaging and possible incision and drainage (I&D). Review of an ER provider report dated 07/08/24 revealed Resident #10 was seen for an open wound of the abdominal wall. He presented for a wound check and had an abnormal CT of the abdomen. He had a non-healing wound to his upper abdomen and he had an increase of purulent bloody drainage. The ER report indicated the resident was supposed to be using a wound vac, but it was not applied yesterday evening per report from Emergency Medical Services (EMS) personnel. The resident reported persistent abdominal discomfort as a 7 on a scale of 0 to 10. Review of the hospital history and physical (H&P) dated 07/08/24 revealed Resident #10 had a history of necrotizing fasciitis and an abdominal wall abscess. He presented to the hospital with a small open wound in the left flank area with purulent drainage. CT scan showed a persistent gas fluid pocket in the superficial aspect of the left abdominal wall surrounding a non-radiopaque foreign body, such as a retained surgical sponge. He was admitted with a recurrent left flank abdominal wall abscess. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER: Continuing Healthcare at Willow Haven		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a surgical consult by Surgeon #150 dated 07/08/24 revealed he saw Resident #10 for a left flank wound being warm and firm with purulent drainage coming from a small open wound. CT scan obtained on 07/08/24 revealed concern for a retained foreign body in the abdominal wall. An abdominal assessment showed mild tenderness to the left flank with erythema and induration. A small wound to the left flank was present with malodorous drainage. The results of the CT scan obtained on 07/08/24 revealed a foreign body measuring 14 cm in length by 1 cm in width and a 10 cm cranio-caudal diameter. The impression from the CT scan was a persistent gas fluid pocket in the superficial aspect of the left abdominal wall surrounding the non-radiopaque foreign body, such as a retained sponge. The assessment/ plan indicated left flank/ abdominal wall abscess and small wound remained to the left flank though most of it was closed over. CT scan revealed what appeared to be a retained sponge from most likely a previous wound vac dressing. It would need to be removed and likely a debridement of the abdominal wound. The CT scan and abdominal exam revealed a foul smelling abscess, a healing wound that most likely had a retained sponge from his wound vac care near the undermined cavity that was grossly infected, needed to be removed and the area debrided. Review of the operative note by Surgeon #150 dated 07/09/24 revealed his pre and post operative diagnosis was a foreign body. A palpable cavity fluid collection was opened using a skin incision under general anesthesia with a large amount of purulent thick fluid that not entered, but cultures were obtained. A second incision was taken down to the large fibrous cavity where the foreign body was identified and removed. Findings of the foreign body revealed a retained large white vac sponge. Review of a skin grid non-pressure wound assessment, dated 07/17/24, revealed Resident #10's left flank wound was assessed upon his return to the facility. The wound that originated on 05/11/24 and was a surgical wound deteriorated from when it was last assessed (07/03/24) and measured 27 cm x 13 cm x 2 cm. Tunneling was not present, but undermining was noted between 6-12 o'clock and at 3 cm. A large amount of serosanguinous drainage was noted, was free of any odors and free of signs of infection. The decline in the wound was related to surgery while in the hospital. Review of the facility's timetable of the events pertaining to Resident #10's wound vac and it's related complications revealed the events began when the resident was seen by Wound Physician #100 on 07/03/24 and ordered a CT scan to be completed and to follow up with the resident's surgeon due to increased drainage in his wound vac. Due to it being a holiday, the CT scan was going to be scheduled on 07/08/24. On 07/08/24, the resident's dressing was noted to have come off with a large amount of drainage. The nurse went in to assess the drainage due to the wound vac dressing being scheduled to be changed. The nurse noted redness and excessive drainage. The nurse immediately notified the nurse practitioner and the physician of the concern. The physician (Physician #135) was in the facility, assessed the resident, and requested that the nurse place an ABD over the wound and to send the resident to the ER. The nurse sent the resident to the ER and the ER noted a foreign body in the wound via a CT scan. During the debridement of the wound, they discovered it was white foam from the wound vac dressing. An interview with the nurse revealed she did not remove the white foam before sending the resident to the hospital due to Physician #135 stating to place an ABD dressing over the wound and to send the resident out. As a result of the incident, all nurses were educated on timely treatment when a wound vac was leaking and completing a full assessment of the wound before sending to the ER. The transport scheduler was educated on pulling the order listing report and attempting to make appointments the next business day after the order was received. (continued on next page)

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	08/08/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of email correspondence from the involved employees (obtained as part of the facility's related investigation that went along with their timeline) revealed accounts of the incident were provided by the nurse and the aide that were on duty for the night shift on 07/08/24, when Resident #10's issues with his wound vac started. An email from LPN #222 sent 07/10/24 at 9:52 A.M. revealed on the early morning of 07/08/24, she was notified of red drainage from Resident #10's wound vac site. The resident rolled to his right side and the nurse observed red drainage on a towel that the aide had placed under his dressing. She checked the tubing and pressed the edges of the dressing in an effort to check the seal. She claimed she saw red fluid in the tubing moving down towards the wound vac machine. The wound vac machine was on at that time. She checked the orders in the electronic medical record (EMR) and saw where thee dressing was to be changed on Monday. An email from LPN #245 sent 07/10/24 at 10:05 A.M. revealed on 07/08/24 around 9:00 A.M. to 9:30 A.M. she went into Resident #10's room to assist another nurse (LPN #120) with changing the resident's wound vac due to it getting changed every Monday, Wednesday, and Friday. When she entered the room to get the supplies ready, an aide showed her that it had been leaking for a while. LPN #120 entered the room and the two nurses assessed the wound. The wound was noted to be red/ pink, hot to touch, hard, and poured out with bloody drainage when touched or when they turned him. The nurses agreed it was not a good idea to put the wound vac back on and LPN #120 called the nurse practitioner (NP). The NP gave the orders to apply a wet to dry dressing, draw blood, and get a wound culture. Around 10:30 A.M., Physician #135 came in and examined the wound with LPN #120 present. The physician gave an order to send the resident to the hospital. An email from State tested Nursing Assistant (STNA) #200 sent 07/10/24 at 10:31 A.M. revealed Resident #10's wound vac on his side was coming off and leaking everywhere. She placed a folded sheet under his side as that was all she had on hand when she noticed it. She told the nurse about it (dressing) being almost completely off and leaking everywhere. She told the nurse right after her last rounds when she noticed it coming off. She thought it was probably around 6:00 A.M. The nurse replied to her that the dressing was scheduled to be fixed that day. Review of in-service records revealed the facility provided education to their nursing staff on 07/10/24. The education provided included a directive that, if a wound vac was off or not functioning properly, wound vac needed to be reinforced or changed no matter the time. When changing the wound vac, it was best practice to assess the wound bed and properly clean prior to placing a new wound vac. An in-service record dated 07/10/24 revealed education was provided to the transportation aide regarding the need to run the order listing daily. All orders needing appointments were to be called and made within the following business day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/07/24 at 2:27 P.M., an interview with Wound Physician #100 revealed he had been managing Resident #10's wounds for months now. He confirmed he had seen the resident on 07/03/24 and ordered a CT scan to be done and wanted a re-consult with the surgeon due to an increase in drainage noted in the resident's wound vac. He was not aware that the CT scan had not been scheduled and the consult with the surgeon had not been made by the facility prior to the resident being sent out to the hospital on 07/08/24. He was told the consults were made but there was some issue getting them done around the holiday/ weekend. He did not order the CT scan to be done emergent, but he would have expected them to call to schedule the CT and make the appointment for the consult with the surgeon by at least Friday. He was not sure if the CT scan would have been able to be scheduled on the holiday and the ability to get him in for both would depend on staffing around the holiday and the schedules. He indicated the resident's wound had a small opening with a big tunnel under it between 06/19/24 and 07/08/24. He was not aware of there being any problem with the resident's wound vac leaking or it not being in place the evening of 07/07/24 going into 07/08/24. He stated it would have been his expectation for the facility's nurse to contact him if there was a problem with the resident's wound or his wound vac. The last time he saw the resident's wound on his left flank area was on 07/03/24, when he had increased drainage prompting him to order the CT scan and the consult with the surgeon. The resident's wound had looked like it always had the last time he saw it with the exception of the increase in drainage. He had not been told that the resident's wound vac had been left off for any length of time the early morning hours of 07/08/24. He indicated, even if the wound vac was just leaking and was not fully off as was indicated, there would not have been a proper seal and suction for it to be effective in removing the wound drainage. He was unaware of the foreign body that was removed from the resident's wound while he was in the hospital. He had not had the opportunity to see the surgeon's operative note or the consult that was done while the resident was in the hospital. He acknowledged that the foreign object ended up being a 14 cm x 1 cm piece of white foam that was used for his wound vac treatment. He indicated the white foam was less porous and, if it had been left in when they removed the wound vac when sending the resident to the hospital, it would have prevented the wound drainage from getting out of the tunneled area and increase the risk for infection. He also stated you could not leave the foam in a wound when the wound vac was not in place and functioning properly, as it would adhere to the wound bed rather quickly. He reported it would be speculation on his part to say if the problems he was having with the wound vac not being on and the dressing not being in place caused his infection he was found to have in the hospital. He stated the resident was known to have a history of getting infections quickly, so it was a possibility. (continued on next page)

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER: Continuing Healthcare at Willow Haven		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/07/24 at 5:05 P.M., an interview with LPN #222 revealed she had worked at the facility since February 2024. She denied having received any training on wound vacs prior to taking care of Resident #10 with his wound vac. She stated most of what she learned was on the job. It was not until after the incident on 07/08/24 that they received training on wound vacs. She was comfortable with checking the seal and reinforcing the wound vac dressing, but she did not feel comfortable changing the dressing. She had reinforced them in the past to get them to work properly without having to change it all. She was aware if the resident's wound vac was not working properly they could take it off and put a wet to dry dressing on it. She recalled the resident's wound vac dressing that was clear had red drainage under it. An aide came to her and told her about putting a towel under the resident because it was leaking. She claimed she checked it and the wound vac dressing was intact and sucking up drainage. It was sometime between 2:00 A.M. and 5:00 A.M. when she was made aware of the red drainage coming from the wound vac dressing. The machine was on when she checked it and the dressing was intact. She pressed around the edge of the dressing to verify it was intact. She denied she had to reinforce the dressing. The resident told her when she was in there the dressing was due to be changed that day. The aide had told her about the resident having drainage on his pad under him. She assumed the drainage was from his wound vac. There was a rolled up towel under his left side when she checked him. She reviewed the resident's EMR and saw something about drainage from the wound vac and the doctor already being aware. She recalled the order for the CT scan of his abdomen and the surgical consult so she thought it had been addressed. She did not feel the need to contact the physician since apparently the drainage he had was already known. She denied turning off the wound vac or removing his wound vac dressing. She assumed she would have notified the oncoming shift about an increase in the drainage in the canister, but could not recall specifically doing so. She denied going back into his room after that for any reason. She did not have to give him medications in the morning. She indicated she would contact Med One (an on-call physician service) if there was any problems with the resident's wound or wound vac. On 08/07/24 at 5:12 P.M., an interview with STNA #200 revealed she was the aide that worked on Resident #10's hall the night of 07/07/24 - 07/08/24, when he had the issues with his wound vac. She was told in report by the prior shift that the resident's wound vac had been leaking. She stated it was not that bad when she was in the resident's room earlier the time before she found him between 5:00 A.M. and 6:00 A.M. with a large amount of drainage leaking from his wound vac. The dressing to the wound vac was barely on at that time when she saw him. She informed the nurse about it, but could not recall the nurse's name that she worked with that night. She was not sure if the nurse had gone in and checked on the resident, after she reported that to her. She could not say for sure if the wound vac was on or not. She did not mess with that. She denied there was any drainage present in the tube when she was in there. The drainage she saw was leaking from under the dressing. She recalled, when she told the nurse about it, the nurse said she was not going to worry about it because day shift was due to change it. She changed the pad under the resident and put a folded sheet under him to catch the drainage prior to telling the nurse. She denied she showed the nurse what had leaked onto the pad, prior to disposing of it in the soiled utility room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/08/24 at 8:55 A.M., an interview with Resident #10 confirmed he was having issues with the wound vac Sunday night (07/07/24) going into Monday (07/08/24). It had been leaking a little Sunday evening as was indicated by STNA #200. It was not until he woke up that morning that it was draining a lot and he had all that gunk from his wound drain out into his bed. He indicated the leaking from the wound was a lot heavier early in the morning. He could not recall if the nurse had been in to check him that night or not. He recalled the aide being in there and helping him change his bed. He has had problems with the wound vac in the past and that was the second one he was given. The first wound vac had stopped working during the night and just shut off. He was not sure if that was what may have happened this time as well. He did not recall anyone turning the wound vac off during the night and thinks it may have just done what the first one did and shut off on it's own. He thought the nursing staff had tried to patch it up the best they could. He denied that anyone had changed the wound vac dressing, after it was leaking, when it was ordered to be changed as needed (PRN) as well. He was not sure if the day shift nurses that came in found the wound vac off or not. They did find a lot of drainage in his bed though. He was aware of the order Wound Physician #100 gave on 07/03/24 for a CT scan of the abdomen and a referral to his surgeon. The wound physician told him he was going to order that when he was there Wednesday (07/03/24). He felt the facility staff dropped the ball with that as no one tried to schedule those for him before he ended up in the hospital on 07/08/24. He referred to the large wound he came back from the hospital with as his [NAME] bite. He referred to it as that because that was what it looked like. He indicated his wound looked like a [NAME] bit him on his side and just ripped the tissue away. Physician #139 told him when he saw him on 07/08/24 that he likely had a worse infection than his last. He was worried if he did not get him to the hospital that things were not going to end well for him. On 08/08/24 at 10:32 A.M., an interview with LPN #245 confirmed she worked day shift on 07/08/24, when Resident #10 was found to have problems with his wound vac and was sent to the hospital. She entered the resident's room with LPN #120 to change his dressing around 9:00 or 9:30 A.M. They both entered the room around the same time. She was not aware there had been any problems with the resident's wound or his wound vac treatment. When they went into the room, they noted his wound vac was leaking. The bandage around the wound vac was wet from the drainage and was not sticking to his skin. The area around the wound was red, hard, and warm to touch. The dressing was still intact but was peeling off where it had gotten wet. She denied she looked at the wound vac to see if it was on or looked at the tubing to see if anything was being sucked up through the tubing. She was on the opposite side of the bed and not in view of either. LPN #120 was on that side of the bed. She did not hear any beeping of the wound vac machine that would have indicated there was an active problem with the seal or it suctioning. They both decided it would be best not to put the wound vac back on. LPN #120 called the NP and got orders for a wet to dry dressing to be applied and to stop using the wound vac. She was not sure if the wet to dry dressing got put on, but knew LPN #120 went to get the supplies. She was told by LPN #120 that she did not need help with the dressing change since they were not putting on a wound vac dressing. She was not in there to see if LPN #120 removed any foam when switching it over to a new dressing. Physician #135 was in there 30-35 minutes later and gave the order for the resident to be sent to the hospital, as he was concerned about him filling with fluid again and would need an I&D. She was aware of the order for the CT scan of the abdomen and a surgical consult that was ordered by Wound Physician #100. She was not sure if it was ever set up. The transportation aide was the one that set up appointments. The nurses put the orders into the computer and the transportation aide checked them daily when she was there to see if anything needed scheduled. She did not know if the transportation aide worked Thursday (July 4th), but knew she was there the day after. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Willow Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy on Negative Pressure Wound Therapy, Dressing Change from Long Term Care Clinical Procedures by [NAME] Healthcare 2015 revealed the documentation guidelines included in that policy/ procedure was to notify the physician when a change in wound condition was noted. Notification was also needed when the current treatment did not appear to be effective or no improvement in wound status was noted. This deficiency represents non-compliance investigated under Complaint Number OH00155961.