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	12/07/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of concern reports, review of dental treatment plan quotes, email correspondence between facility staff and the corporate office, resident interview, family interview, staff interview, and policy review, the facility failed to ensure a resident's concern pertaining to missing upper dentures were addressed timely for a resolution. This affected one (Resident #17) of three residents reviewed for missing property. Findings include: Review of Resident #17's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included hemiplegia and hemiparesis affecting his left non-dominant side, bipolar disorder, major depressive disorder, abnormalities of gait and mobility, and bilateral hearing loss. Review of Resident #17's profile revealed his payer status was Ohio Medicaid (MCD). The census tab in the electronic medical record revealed the resident resided on the 400 hall when he was first admitted and was moved to the 100 hall on 08/09/24. Review of Resident #17's Personal Effects Inventory assessment completed on 07/24/24 revealed he was known to have dentures. Both upper and lower dentures were indicated to be part of his inventory when he was admitted . Review of Resident #17's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was not known to have any communication issues. He was able to make himself understood and was able to understand others. He was also cognitively intact and was not known to display any behaviors or known to reject care. The resident was coded on the MDS as being edentulous (no natural teeth). It did not assess if the resident had the use of any dentures just that he did not have any broken or loosely fitting full or partial dentures. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #17's care plans revealed he had a care plan in place for being at risk for oral/ dental health problems related to edentulous status. The resident had upper and lower dentures. The care plan originated on 07/29/24. The interventions included the need to monitor/document/report to nurse/MD/family as needed any signs or symptoms of oral/dental problems needing attention: pain (gums, toothache, palate), abscess, debris in the mouth, lips cracked or bleeding, teeth missing, loose, broken, eroded, decayed, tongue (black, coated, inflamed, white, smooth), ulcers in the mouth, lesions; obtain dental consults as needed; and coordinate arrangements for dental care/ transportation as needed/ as ordered. Review of the facility's Concern Reports for the past three months revealed there was a concern report that pertained to Resident #17 on 10/01/24. The Concern Report indicated he had reported his upper dentures were missing on that date. The person completing the form was Activities Director #100 and the investigator of the complaint was identified as Licensed Social Worker (LSW) #115. The investigation report indicated a dental appointment was scheduled for 11/04/24. Follow up on the investigation report indicated a cost quote was given to facility's Administration for approval and had been sent to corporate for review on 11/04/24. Review of a treatment plan for Resident #17 from the denture provider revealed an estimate was provided to the facility for the replacement of dentures for the resident on 11/04/24 (over a month after they were reported as missing). The cost for the replacement was quoted at $1,488.00. The cost was not going to be covered by insurance and the estimated patient cost was going to be for the full amount. Review of email correspondence from the facility's social worker on 11/04/24 at 8:54 A.M. to the contracted in-house dental company revealed the social worker reached out to them to inquire as to what a set of dentures cost out of pocket. The scheduling assistant from the dental company responded on 11/04/24 at 9:59 A.M. and informed the social worker that the cost would be $705.83 per arch. Review of email correspondence between the facility's social worker and the facility's Administrator on 11/04/24 at 12:41 P.M. revealed a new set of dentures for Resident #17 was going to cost $1,411.66 (705.83 for the top and 705.83 for the bottom). The Administrator replied to the email with a thank you. Review of an email correspondence from the facility's Administrator on 11/05/24 at 2:39 P.M. to the [NAME] President of Operations with the facility's corporate office revealed the Administrator notified the corporate office that they had a resident (Resident #17) that lost their dentures when they were not in the resident's mouth. The Administrator indicated she attached the quote to get them replaced. She then asked if they were good to continue. The Administrator also typed in her email that they had checked with (named) dental provider (which the resident had previously refused services with) and the cost was projected to be the same. A response was received from the [NAME] President of Operations on 11/05/24 at 2:45 P.M. with a couple of questions. She wanted to know, if they felt the staff lost them, and how the resident had been eating without them, inquiring as to if his diet had been changed. She further stated they typically did not pay for dentures, unless they knew their staff were at fault. The Administrator replied on 11/15/24 at 1:43 P.M. that the resident and the staff were saying they were there when he arrived. He (Resident #17) was very alert. The Administrator indicated she did feel like there was a possibility they were placed on his tray and got thrown away when trays were picked up. That was an assumption and they did not have any way of truly knowing. He (Resident #17) was asking for an update on the replacements. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the final email correspondence between the facility's Administrator and the [NAME] President of Operations from the corporate office was on 12/04/24. The Administrator sent her email at 11:02 A.M. asking if they had approval to order the dentures. The Ombudsman was indicated to be involved and was asking for an update on the denture replacement. The response from the corporate office was on 12/04/24 at 11:04 A. M. The email indicated the [NAME] President of Operations thought they could meet in the middle and they would pay half since they did not know what happened to them. She asked if everyone agreed (referring to the facility's Administrator, a sister facility's Administrator, and the corporate office's Chief Nursing Officer). The sister facility's Administrator replied on 12/04/24 at 11:23 A.M. that it sounded good to her and the facility's Administrator responded at 11:25 A.M. that she agreed, as well, and it sounded good. She thanked the [NAME] President of Operations when ending her communication with her. On 12/07/24 at 10:47 A.M., an interview with Certified Nursing Assistant (CNA) #144 revealed she had worked at the facility for about a year now and worked on Resident #17's hall (100 hall). She reported the resident had the use of dentures and had stated multiple times he came in on the 400 hall with full upper and lower dentures. Sometime around the time he was moved from the 400 hall to the 100 hall his upper dentures became missing. She reported the resident had talked with all the nurses about it, as well as the transportation aide and the administrator. They made him a dental appointment, but the resident was told his insurance was just not paying for it. She was not sure what was going on with the missing upper dentures now other than they were still missing. She verified he had lower dentures sitting in a cup in his bathroom, but she had not seen him have the upper dentures since she took care of him on the 100 hall. She reported the staff did have to assist the resident with his activities of daily living care that included the care of his dentures. She denied he was wearing his lower dentures due to not having the uppers and he could not keep the lowers in place without the uppers being in. On 12/07/24 at 11:00 A.M., an interview with LPN #155 revealed she generally worked the 400/ 500 hall mostly and had taken care of Resident #17 when he was on the rehabilitation hall. She confirmed the resident had full upper and lower dentures when he was on the 400 hall. She recalled they were brought in for the resident at the same time his wheelchair was brought in shortly after he was admitted . The staff did assist the resident with his oral/ denture care and helped him put them in a cup when not in use. She had not heard that the resident's dentures had come up missing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/07/24 at 11:30 A.M., an interview with Resident #17 revealed he was admitted to the facility back in July of 2024. He was on the 400 hall at the time, but had since been moved to the 100 hall. He had full upper and lower dentures when he was first admitted . He confirmed staff had assisted him with his oral care and the care of his dentures. He indicated they were storing his dentures in an emesis/ spit basin, when he first came and not in a denture cup. His dentures were taken out every night when he went to bed and denied that he left them in when sleeping. He stated he woke up one morning, after they were removed and put in an emesis basin on the bedside table next to his bed, and they were gone. It had been so long ago he could not remember exactly if it was on the 400 hall or the 100 hall when that occurred. He was informed he was moved from the 400 hall to the 100 hall on 08/09/24. He stated it would have been when he was on the 100 hall then. They had been missing since August. He told people and claimed he had told them all multiple times. They would always just tell him they were waiting on corporate. He indicated his insurance would not cover a replacement pair of dentures, as they already covered them once. He was told he could only get a new set under MCD once every seven years or so. It had only been a couple years since had had gotten his last pair. He confirmed he was sent to an offsite denture provider in November 2024. After sitting there for a half hour, they informed him his insurance would not cover and they did not accept MCD. He denied that they took impressions or did anything else. The facility staff finally provided him with a denture cup the day he went to the outside dental provider. He stated up until then he was using a gray emesis/ spit basin to keep his dentures in. The denture cup was observed in the cabinet in his bathroom and was noted to only contain a lower denture. There was not an upper denture plate found in his cup. He was frustrated with how long it had taken to get anything done about the missing denture. He was not aware the facility was having any discussions with the corporate office or that it was decided they (corporate office) had approved to cover half the cost of the replacement. He was not good with them just offering to pay half the cost of replacement dentures. He stated he had no money to pitch in for the replacement. He thought the upper denture likely got mixed in with his bed linen when taken to laundry or were thrown away by mistake. The last time he got dentures made they cost him around $1,400.00 dollars. On 12/07/24 at 12:42 P.M., an interview with LSW #115 revealed she had been the facility's social worker for the past year and a half. She confirmed she was the assigned employee that did the investigation for Resident #17's reports of missing upper dentures that was made on 10/01/24. She started the investigation and then turned it over to the facility's Administrator. Her part involved checking to see if he had consented to receive dental services and talked with transportation to set up an appointment for him to be seen by an outside dentist. They opted for the outside dental appointment due to the resident not consenting to dental services from their in-house contracted dental company. When the resident returned with a cost from the outside dental provider, she went ahead and got a quote from the in-house dentist to see how much denture replacements would be. She was not sure of the exact cost but recalled they would be about $700.00 dollars per plate. She then forwarded the cost on to the Administrator and the Administrator forwarded it to the corporate office. She was not sure why it took so long to resolve the issue or to at least get approval to proceed with the replacement of the lost denture. She was told by the Administrator recently that the corporate office said they would pay half. She was not sure who would pay the other half as the resident was under MCD and had no money. She agreed that the facility should be responsible for replacing the lost denture since the resident was known to have full upper and lower dentures and the upper denture went missing while he was under the care of the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/07/24 at 12:54 P.M., an interview with Activities Director #100 revealed she recalled completing a concern report for Resident #17's reports of a missing upper denture. She stated that was made known during a resident council meeting in October 2024. She completed a concern form for it and gave it to the facility's social worker. That was the first time she had heard the resident report his upper denture being missing. The resident brought the concern up again during their most recent resident council meeting held in December 2024. She remembered the resident saying in the October 2024 meeting that they had been missing for quite a while. She knew the resident was taken to the dentist and from what she heard he was not eligible to get another set made due to it being too soon since his last pair for his insurance to pay for it. She put the concern in again, after the December 2024 resident council meeting. On 12/07/24 at 1:02 P.M., an interview with Resident #17's son (emergency contact #1) revealed he was not aware the resident was missing his upper denture. He stated, if they had been misplaced while in the facility, then they needed to be replaced. He denied the resident had any money to be able to replace them. He felt, if they were lost while in the facility, then the facility should have to pay to replace them. On 12/07/24 at 1:10 P.M., an interview with the facility's Administrator revealed she was aware of Resident #17 having reported his upper denture was missing. She acknowledged the first concern report regarding the missing upper denture was completed on 10/01/24. She had been working with the corporate office and was awaiting their approval for replacement. She confirmed they received an email on 12/04/24 that the corporate office agreed to pay for half the cost of the replacement. She acknowledged the resident was under Ohio MCD and his last pair had been made about two years ago. He did not qualify to have another pair made under MCD, as they only provided them once every seven years. She further acknowledged the resident indicated he had no money to help cover the cost of the replacement and, since they were misplaced/ lost while in the facility they should be responsible to cover the cost to get them replaced. The facility's policy on Concern Procedure revised December 2021 revealed the facility believed the resident had the right to voice concerns to the facility or other agency or entity that heard concerns without fear of discrimination or fear of reprisal. When a resident voiced a concern, the following procedure would be followed: 1.) a resident concern report would be completed by the resident with the assistance as needed providing as much detail as possible. 2.) The resident concern report would then be taken to the Director of Social Services and logged onto the Resident Concern Report Log for tracking and trending. 3.) The Director of Social Services would notify the appropriate department manager involved in the concern and a follow up investigation would be initiated. 4.) The department manager would document the investigative findings on the report. 5.) The department manager and/ or the Director of Social Services would review the findings/ resolution with the resident and obtain the signature of the resident filing the concern. 6.) The Administrator would review and sign the Resident Concern Report. 7.) If the resident was not satisfied with the findings/ resolution, the resident may request the concern be transitioned to a grievance with the Director of Social Services serving as the facility's grievance officer. The facility was committed to working diligently to resolve each concern brought forward by their residents. Each Resident Concern Report was different and the time frame to reach a resolution would vary. The investigating department manager would periodically update the resident on the status of the investigation as they proceeded through the investigation. This deficiency represents non-compliance investigated under Complaint Number OH00160261.