

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 01/29/2025
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)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019</p> <p>Based on record review, policy review, and interview, the facility failed to ensure timely resolution of a concern regarding missing resident property. This affected one (Resident #10) of three residents reviewed for misappropriation. The facility census was 74.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, diabetes mellitus, anxiety disorder, depression, and personal history of malignant neoplasm of the lip, oral cavity, and pharynx. The resident expired and was discharged on [DATE].</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the resident had moderately impaired cognition.</p> <p>Review of a Concern Report, dated [DATE], revealed Resident #10's power-of-attorney (POA) filed a concern regarding Resident #10's missing rollator walker, dentures, and glasses following a hospitalization on [DATE]. The Concern Report revealed the Administrator called the inpatient psychiatric hospital on [DATE] and left a message, with no response received.</p> <p>Interview on [DATE] at 9:35 A.M. with Social Services Designee (SSD) #64 revealed Resident #10 left the building with his walker when he was transferred to the hospital on [DATE], however, upon his return, the walker was not received.</p> <p>Interview on [DATE] at 10:55 A.M. with the Administrator confirmed the last phone call or attempt to provide a resolution for Resident #10's POA's concern regarding missing dentures, glasses, and walker was made on [DATE]. The Administrator further confirmed the resident did have dentures, glasses, and a walker upon admission to the facility.</p> <p>Review of the facility's policy, titled Resident Rights, dated [DATE], revealed each resident has the right to retain and use personal possessions including furnishings and clothing, as space permits.</p> <p>This deficiency is an incidental finding discovered during the complaint investigation.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366244
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019</p> <p>Based on closed medical record review and interview, the facility failed to ensure comprehensive resident information was provided to the receiving facility regarding a transfer. This affected one (Resident #10) of three residents reviewed for death. The facility census was 74.</p> <p>Findings include:</p> <p>Review of the closed medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, diabetes mellitus, anxiety disorder, depression, and personal history of malignant neoplasm of the lip, oral cavity, and pharynx. The resident expired in the facility and was discharged on [DATE].</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the resident had moderately impaired cognition. The resident required supervision or touching assistance with ambulation, showering, and personal hygiene.</p> <p>Review of Resident #10's Transfer Form, dated [DATE], revealed under Section E: the facility failed to include accurate resident representative information. The resident's son was power-of-attorney (POA)/resident representative and this was not documented on the form.</p> <p>Interview on [DATE] at 12:21 P.M. with the Administrator confirmed Resident #10's Transfer Form did not reflect accurate resident representative information.</p> <p>This is an incidental finding discovered during the complaint investigation.</p>		