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	08/21/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review and interview, the facility failed to maintain a clean and sanitary physical environment, failed to ensure a homelike dining experience and failed to ensure adequate supplies/linens were available for resident use. This affected 16 residents observed eating in the main dining room (Resident #2, #3, #6, #8, #15, #18, #19, #20, #25, #28, #29, #31, #44, #45, #47, and #52), three resident's (#9, #69 and #80) air conditioner unit, nine resident rooms (Resident's #2, #6, #8, #18, #19, #45, #47, #65 and #80) and had the potential to affect all 68 residents residing within the facility. 1.On 08/11/25 between 11:28 A.M. and 11:35 A.M., observation and interview with Resident #59 revealed upon entering the room the floor was sticky causing your shoes to make a snapping noise as you walked across the floor. Interview with Resident #59 at the time of the observation revealed she was unaware what was on the floor that made the entire floor sticky and she said it had been that way for a day or so. The resident's waste paper basket was overflowing with trash and the resident's privacy curtain was observed to have a brown and white substance scattered on it. Observation of the resident's bathroom revealed the floor was sticky and the caulking around the base of the toilet was stained with a brown/black substance. The above was verified by Certified Nurse Assistant (CNA) #132 and Housekeeping #137 at the time of the observation. Review of the Housekeeping Log revealed staff check marked rooms as they were cleaned/floors mopped/etc. Review of the Housekeeping Log dated 08/09/25 and 08/10/25 revealed Resident #59's room had not been cleaned/floors mopped/trash emptied. On 08/19/25 at 9:56 A.M., interview with Housekeeping Manager #113 revealed housekeeping was not able to get everything done on the weekends due to only having one housekeeper. The Housekeeping Log was to help keep track of what rooms were cleaned and what rooms still needed to be cleaned. Housekeeping Manager #113 stated during the week she helps out but she does not work weekends normally. The facility was currently looking for another housekeeper to hire. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Continuing Healthcare at Willow Haven	1020 Taylor Street Zanesville, OH 43701

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 08/11/25 between 12:30 P.M. and 12:41 P.M., observation of the main dining room lunch meal revealed a contracted pest control employee (Orkin) was observed entering the main dining room while Resident #2, #3, #6, #8, #15, #18, #20, #25, #28, #29, #31, #44 and #52 were eating lunch. Pest Control Employee #197 was observed spraying a chemical substance along the base of two doors in the activity/dining room. Pest Control Employee #197 then walked over to the sink area, opened the cabinet beneath the sink, removed a used glue mouse trap and discarded the trap. Pest Control Employee #197 removed a new glue trap and placed it under the sink. Pest Control Employee #197 then entered the kitchen and was observed entering the kitchen without a hairnet. At the time of the observation, Regional Culinary Manager (RCM) #195 was informed of the observation and entered the kitchen. RCM #195 verified the Pest Control Employee was in the kitchen without a hairnet during meal service. RCM #195 verified it was not appropriate or homelike to spray pest chemicals during the resident meal service. Review of the pest control Invoice/Service Ticket dated 08/11/25 revealed no activity was detected and preventative treatment for target pests was performed. Treatment included PT Fendona Pressurized Insecticide. Review of the material Safety Data Sheet for PT Fendona Pressurized Insecticide dated 03/16/21 revealed aspiration hazards included the insecticide may be fatal if swallowed and entered the airways. General safety and hygiene measures included to keep away from food, drink and animal feeding stuff. 3. Medical record review revealed Resident #9 was admitted on [DATE] with diagnoses including Parkinson's disease, dystonia and cachexia. On 08/12/25 at 9:20 A.M., observation of Resident #9's room (209-B) revealed the fall mat was cracked and not a cleanable surface, the air conditioning unit (AC unit) was dripping water from the AC unit vent onto a bath blanket placed on the floor. The AC unit was observed with black debris/mildew pooling on the vents and dripping onto the floor. The resident's upper portion of the bed was positioned away from the wall and a bath mat was observed on the floor below the AC unit. The resident had a cork board hanging on the wall below the AC unit that had cards and pictures pinned to it. The cork board was observed to have dried black stains extending from the top to the bottom on bilateral sides of the cork board approximately one to three inches in width. At the time of the observation, interview with Family #204 revealed the facility was notified of the leaking air conditioner unit at the beginning of summer and it was still leaking. Family #204 stated he had come in to visit and Resident #8's pillow was soaked from the AC unit above her bed dripping onto the bed and black debris/mold was on the slats of the AC unit and on her bed linens. Family #204 stated it has not been fixed and pointed to the cork board hanging beneath the AC unit and the black stained areas on both sides from the AC unit. There was also a bath blanket on the floor between the wall and the resident's bed that had dried water stains and grey/black splattered areas. The drywall and baseboard along the floor was observed to be black and the baseboard was pulling away from the drywall. Family #204 stated he was concerned that the black mold would make Resident #9 sick. 4. Observation of the environment on 08/11/25 between 10:36 A.M. and 1:27 P.M. revealed the following: - room [ROOM NUMBER] with Resident #2 had the left side of the bed against the wall. There was paint scraped off in an approximate eight foot area of the wall exposing the drywall. The floor of the resident's room had was dark and dirty with paper and debris on the floor. The floor had no shine. - room [ROOM NUMBER] with Resident #45 the floor was dull, dirty with dark streaks on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- room [ROOM NUMBER] Resident #19 one third of his headboard was broken off. Interview 08/11/25 at 11:05 A.M. with Resident #19 revealed his headboard sounded like a gun went off when it broke a couple weeks ago. It was still not replaced. -room [ROOM NUMBER] with Resident #6 the back wall of his room was scraped up in an approximate eight foot section. His floor was darken and dull. -room [ROOM NUMBER] with Resident #47 the floor was dull and soiled. - room [ROOM NUMBER] with Resident #18 his bed was against the wall. There was an approximately three by two foot area, on the wall he would be looking at if he rolled on his right side, where the paint was scraped off exposing the drywall. - room [ROOM NUMBER] with Resident #8 the floor was dirty. There was also a cup, a [NAME] box, mail, and pencil sharpener on the floor. On 08/11/25 between 2:43 P.M. and 2:54 P.M. Licensed Practical Nurse #179 verified the dirty floors, damaged walls and headboard. Interview on 08/19/25 at 10:08 A.M. with Housekeeping Staff #113 said on the weekends there is only one housekeeper. We are down a person. She said not every room gets cleaned on the weekends. Review of the list of rooms cleaned over the weekend of 08/09/25 and 08/10/25 revealed rooms [ROOM NUMBERS] were described on the list of observation and not cleaned by housekeeping on 08/09/25 or 08/10/25. In addition rooms 205, 302, 413, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, and 512 were not cleaned over the weekend due to one housekeeper only working. 5. Observations included: - On 08/11/25 at 10:36 A.M. Resident #2 had a pillow behind her head without a pillow case on it. - On 08/11/25 at 11:07 A.M. it was noted Resident #19 had a heel boot on the floor that was heavily soiled with dry drainage. He was on a special air mattress. The blue cover of the air mattress was heavily soiled with white flakes and dried debris. He had a pillow under his head without a pillow case on it. Verified at the time of the observations with Licensed Practical Nurse (LPN) #179. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/12/25 at 10:39 A.M. with Central Supply/Medical Records #127 staff they run out of supplies at times such as medium and large gloves. The corporation likes them to use Tri-State because their prices are lower on some things. However, they are not reliable for delivery. Sometime they come on Monday, Tuesday, or Wednesday. She orders three cases each of medium, large and extra large gloves and usually only have extra large left. She tried to keep two cases of wet wipes in the office for emergencies. She does not put them in the central supply room so they are not used daily. Wipes are not kept in rooms. She came in on a Saturday and bought gloves locally and brought them in. She bought three or four boxes at Walmart. We were not out of gloves completely. There were still extra large gloves in the building. They can also borrow from sister facilities. There may be ten (10) boxes floating around in the halls for the 68 residents. Staff will put a medium box on one side of the hall and a box of large on the other side of the hall. The supply room had one box of extra large in the supply room. She had eleven boxes in her office, of extra large. There are no wet wipes on the shelf. She has one full box of 50 wipes and a partial box in her office. She thinks a nurse has a key to get in her office if she needs to get the wet wipes or the extra large gloves. They are not put on the shelf. She manages the supplies like the person taught her who she took the job over from a few months ago. Interview on 08/13/25 at 12:46 P.M. with Licensed Practical Nurse (LPN) #108 and Central Supply #127 revealed there were two boxes of tissues left in the facility until the next shipment next Tuesday, in six days). There were no medium or large gloves. There was one box of extra large gloves in the supply room. They indicated they ran out of laundry even before the fire. On 08/13/25 at 1:04 P.M. observation revealed Resident #2 had no gloves in her room and needed assistance with a large bowel movement. Interview on 08/13/25 at 1:10 P.M. Housekeeping #137 revealed they have run out of toilet paper and paper towels. She had no tissues left to place in rooms. She indicated there is a new person in the central supply position. They have not had enough supplies gloves, toilet paper, Kleenex, paper towels, and linens the last three months. On 08/13/25 at 1:14 P.M. it was noted Resident #18 wanted a tissue and there were no tissues in his room. Observation of seven rooms on 400 hall on 08/13/25 at 4:12 P.M. revealed two of seven rooms had a box of gloves. Some almost empty. Rooms 403, 404, 408, 409, and 412 did not have a box of gloves. Interview with CNA #185 on 08/12/25 at 6:34 A.M. stated the facility does not stock gloves or incontinence products in the rooms. States most nights only have maybe one box per hallway. No longer can get to extra supplies including linen. Hall 2 had no gloves when she started her shift last night (08/11/25). Cant take the one box in and out of rooms so what are you supposed to do. On 08/12/25 at 6:59 A.M., interview with CNA #112 stated the facility runs short of help frequently and depending on who is working determines if things all get done or not. Management does not come in to help and try to do the required checks every two hours but sometimes they are late. States the facility runs out of linens and gloves and never have large briefs. The briefs they provide the residents do not always fit them so they just lay them out on the bed because it would cut into their skin if they closed the tabs. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/13/25 at 4:22 P.M. with LPN #108 revealed they are encouraged to use soap and water for pericare. They keep wet wipes in the office for emergencies. If they are on the shelf they would use them instead of soap and water. We have run out of gloves that are not extra large. The good sizes are gone. She has had complaints from aides that there are no gloves. The rooms have glove holders with them but no gloves in the holders. They complain frequently about the lack of gloves. 6. Tour of the linen cart and four linen rooms on 08/12/25 between 4:10 P.M. and 4:35 P.M. revealed: Hall 1 linen closet had three washcloths and no bath towels, Hall 2 linen closet had 1 washcloth. Hall 3 linen cart had three towels and two washcloths. Hall 4 linen closet had four washcloths and three towels. Hall 5 linen closet had seven washcloths and no towels. Licensed Practical Nurse (LPN) #179 accompanied the surveyor on the tour and verified the linen count of 17 clean wash clothes and six clean towels in the facility for 68 residents. Interview on 08/12/25 at 4:38 P.M. with Certified Nurse Aides (CNA) #105 and #132 revealed they do run out of washcloths and towels The facility wants them to use soap and water and wash clothes for pericare not wet wipes. They do have wet wipes in housekeeping office for emergency. They do not keep wet wipes in central supply. They also do not have enough gloves in medium and large. They run out. Also, verified they run out of gloves in medium and large and spend a lot of time hunting for gloves because boxes of gloves are not kept in rooms. Interview on 08/12/25 at 4:19 P.M. with Housekeeping/Laundry Supervisor #113 revealed the linens are being washed and dried at a sister facility. She will drop off the soiled linen and personals when she leaves work and pick them up clean in the morning between 7:30 A.M. and 8:00 A.M. What linen is out is what they have until after 8:00 A.M. in the morning. She said she does have some washcloths and hand towels in her office that have not been put out. She included she asks for more linens and they get removed from requisitions due to budget. There were blankets, towels and washcloths approved last week due to the laundry dryer fire and loss of items in the dryer. 7. Interview on 08/12/25 at 12:15 P.M. with Laundry #140 included she was told they did not have enough washcloths and towels. On Monday and Tuesday morning especially there are not enough towels and washcloths. If the stains do not come out of linen they take the linen out of circulation. They tally the linen they take out of production, make a list and requisition more. They have to wash and dry linens and personals. It takes an hour in the washer and a half hour in the dryer. The wash load is split in two and dried half at a time since there was only one functioning dryer. The linen is then folded and brought out to the floor. She will put nothing but towels and washcloths in the washer first thing Monday and Tuesday morning because they are always short those mornings maybe due to less production on the weekends. Since the laundry fire they are sending everything to a sister facility. Facility staff are working after hours there to wash the linens. The clean is then brought back to the facility sorted and distributed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/13/25 at 8:52 A.M. with Laundry/Housekeeping #113 revealed the company formula/par level for washcloths was three washcloths per resident per day, She calculated that with a 67 census she should have 201 washcloths per day. When she did inventory she had nine clean washcloths in the facility. She received 350 washcloths on 08/05/25 and so she put those in circulation on 08/12/25. She did not know where the washcloths for peri care would come from. The facility identified 43 current incontinent residents. Incontinence care is to be provided every two hours. Incontinence care requires three washcloths at a minimum. Three washcloths times 12 incontinence care a day would require 36 washcloths per incontinent resident. Forty three incontinent resident receiving pericare every two hours would need 36 washcloths for pericare a day. Multiply by 43 residents would equal 1548 needed per day for incontinence care. If the 67 residents Laundry #113 identified as a current census used two wash clothes a day for bathing, face washing, etc. that would be a total of 134 washcloths for bathing for a total 1682 washcloths needed a day. Using the facility formula of three washcloths per resident per day the total would be 1759 washcloths need per day instead of the 201 washcloths the corporation identified as a par level. On 08/14/25 at 1:54 P.M. interview with the Administrator, Licensed Practical Nurse (LPN) #179, Registered Nurses (RN) #193 and #194, the Director of Nursing, and Culinary Director #195 verified the corporation wants staff to cleanse residents with washcloths for pericare. They verified the facility would not have enough washcloths to provide care for incontinent residents utilizing washcloths as the corporation prefers. They verified they did not have enough linen, gloves and tissues on hand to provide resident care. 8. a. Interview on 08/11/25 at 11:34 A.M. with Resident #65 included she asked to have her television mounted. She reported it and was told it was on the list. Review of the TELLS maintenance requisitions revealed a request on 04/23/25 to mount Resident #65's television. b. Review of Resident #80's record revealed a 08/04/25 admission with diagnoses including fracture fifth vertebrae T-11 to T-12, end stage renal disease, dependence on renal dialysis (hemodialysis), Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, dysphagia, hypertension, hypocalcemia, and depression. Interview on 08/12/25 at 8:46 A.M. with Resident #80 revealed the television did not work when she arrived, 08/04/25. They did not give her a new one until 08/11/25. Her air conditioner is dirty and smells musty. She said maintenance came in and cleaned it 08/11/25. Observation revealed the front half of the air vents appear to have been wiped off. The back half of the air conditioner vents were soiled dark with dirt/dust. The air conditioner did smell musty when blowing air. Interview on 08/12/25 at 12:13 P.M. with Maintenance #173 verified the TELLS report revealed an entry on 08/05/25 that the resident needed a television. He indicated he was focusing on the fire and then had to find a television so she did not receive a working television until 08/11/25. He also looked at her air conditioner and swept the debris out of the vents of debris. He verified the vents were not clean on the air conditioner and he said he will need to teach housekeeping how to pop out the vents and clean them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/19/25 at 12:06 P.M. with the Administrator revealed they buy televisions for skilled. She thinks residents are taking facility televisions home. She just bought two this weekend. The Administrator revealed maintenance told her he did not know about the air conditioner not working until 08/11/25. 9. Observation on 08/20/25 at 2:17 P.M. revealed Resident #69's air conditioner had visible whitish clumps of lint/dust in the air conditioner vents. There was a puddle of water on the floor under the air conditioner. There was a steady drip coming out of the air conditioner onto the floor. On 08/20/25 at 2:20 P.M. Licensed Practical Nurse #179 verified the air conditioner was dirty and leaking. The deficiency substantiates Complaint Numbers 2588814, 2584767, 2583878, and 2569206.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure residents maintained activities of daily living including range of motion and ambulation. This affected one resident (#59) of six residents reviewed for activities of daily living (ADL). The census was 68.Findings include: Medical record review revealed Resident #59 was admitted on [DATE] with diagnoses including heart failure, unspecified dementia, muscle weakness and cognitive communication deficit. The resident had been receiving hospice services in 2024; however, Resident #59 was discharged from hospice on 01/01/25. Review of the OT (occupational therapy) Discharge summary dated [DATE] revealed therapy recommended ADL assist as needed with no restorative or functional program indicated at that time. Review of the BCRS Scoring Worksheet dated 06/23/23 through 08/15/24 revealed Resident #59 required no assistance with ambulation. There was no therapy screens completed in 2024; however, a therapy screen was completed after the resident slid out of her wheelchair for better positioning. There was no evidence the resident was screened or received therapy/restorative/maintenance services for range of motion (ROM) or her ability to ambulate in 2024 or 2025. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #59 was moderately impaired for daily decision-making, had no impairment of the upper or lower extremities, used a wheelchair for mobility and had received no therapy or restorative programs. Review of the medical record revealed no evidence of a restorative or maintenance program for ambulation or other ADL's. Review of Resident #59's Tasks revealed the following: On 08/02/25, ambulated 50 feet with two turns and walking 10 feet on uneven surfaces with supervision/touch assist.On 08/06/25, ambulated 10 feet with partial/moderate assistance.On 08/07/25, ambulated 50 feet with two turns with substantial/maximum assistance. On 08/09/25, ambulated 10 feet independent On 08/17/25, ambulated 10 feet and ambulated 50 feet with two turns with substantial/maximum assistance. Review of the care plan: ADL deficits related to impaired mobility, dementia and heart failure revised 07/23/25 revealed the resident gets up in her wheelchair, will propel self, often refuses to lay down and stays in her chair even when sleeping. The resident will occasionally refuse care (nail care and shaving facial hair), may need tasks explained/repeated related to diagnoses and hearing impairment. Interventions included to encourage participation with ADL's, break down tasks so ADL's are easier for her and observe for decline in care and report. On 08/11/25 between 11:28 A. M. and 11:35 A.M., observation revealed Resident #59 was sitting in a wheelchair in her room looking out the window. Interview with the resident revealed she wanted to walk again with her walker. The resident stated she had not received any therapy, restorative or range of motion recently and does walk some in the bathroom. Review of the PT Evaluation & Plan of Treatment dated 08/19/25 revealed Resident #59's baseline included the following: the left knee lacked 30 degrees and the right knee extension lacked 10 degrees, dynamic sitting baseline was fair.; however, the wheelchair was too large for her. The resident had not been seen by occupational therapy at this time. On 08/18/25 at 4:55 P.M., interview with Registered Nurse (RN) #193 verified the resident was discharged from hospice on 01/01/25 and the resident had not been screened by therapy in 2024 or 2025 except after a fall. RN #193 verified residents were normally screened by therapy at least every three months. RN #193 was unaware the resident was wanting to ambulate, stated the resident did transfer herself and she would inform therapy. On 08/21/25 at 11:23 A.M., interview with certified nurse aide (CNA) #105 and CNA #107 revealed Resident #59 had been observed self-transferring and taking steps when toileting. Both CNA #105 and CNA #107 stated they had not seen the resident walk in her room independently or in the hallway since they started at the facility several months ago. On 08/21/25 at 1:40 P.M., interview with Rehab Manager (RM) #203 stated residents should be screened quarterly and she was trying to implement this at this building. RM #203 stated Resident #59 had impaired limitations in ROM at this time and needed to improve her ROM. RM #203 verified Resident #59 did transfer herself and take steps but it was unknown what her previous ROM status was as she had not been screened or received any ROM services since being discharged from hospice in January 2025.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Willow Haven	1020 Taylor Street Zanesville, OH 43701

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on medical record review, observation, interview, and policy review, the facility failed to ensure dependent residents were assisted with nailcare and shaving. This affected four residents (#2, #5, #10 and #19) of seven residents reviewed for activities of daily living. The census was 68. Findings Include:1. Review of Resident #2's medical record revealed a 07/12/25 admission with diagnoses including fracture of left femur, vascular dementia, hypertensive heart disease, congested heart failure, depression, muscle wasting and atrophy, abnormalities of gait and mobility, weakness, history of falling, anxiety disorder, Vitamin B deficiency, chronic stage III kidney disease, gastroesophageal reflux disease, disorientation, hypertension, spondylolisthesis lumbar region, and cardiac murmur.Review of a 07/19/25 Quarterly Minimum Data Set (MDS) Assessment revealed the resident was severely impaired for daily decision making and needed substantial/maximum assist for personal hygiene.Review of the resident record included a plan of care dated 08/05/25 activity of daily living self-care performance deficit related to the resident's confusion, dementia, femur fracture, weakness, and recent surgery.Observation on 08/11/25 at 10:36 A.M. of Resident #2 revealed the resident was sitting in her room in a recliner. Resident #2's fingernails on her right hand were long all with dark debris except for the pinky finger. Her left hand, her thumb, and middle finger had long nails with dark debris under the nailbeds.Interview on 08/11/25 at 2:39 P.M. with Licensed Practical Nurse (LPN) #179 verified the resident had long fingernails with debris under the nailbeds.Review of the facility Activities of Daily Living (ADL) policy (updated 02/2024 and approved 05/2025) included activity of daily living services are directed toward the goal of promoting the highest practicable physical, mental and psychosocial functioning of the resident. Activity of Daily Living plans of care may be implemented as appropriate. 2. Review of Resident #10's medical record revealed a 08/24/23 admission and 05/08/25 readmission admission with diagnoses including chronic obstructive pulmonary disease, cervical disk degeneration, chronic peripheral venous insufficiency, need for assistance with personal care, lack of coordination, type 2 diabetes mellitus, intervertebral disc degeneration, lower extremity pain, polyneuropathy, cramps and spasm, hypotension, contracture of muscle multiple sites, insomnia, chronic pain, hyperlipidemia, vitamin D deficiency, deaf nonspeaking, obstructive and reflux uropathy, peripheral vascular disease , benign neoplasm of right adrenal gland, full incontinence of stool, seasonal allergies, open angle glaucoma, anxiety disorder, hypertension and dysphagia.Physician orders did not include any orders related to activities of daily living or positioning. Review of Certified Nurse Aide (CNA) TASK documentation revealed no mention of nail care.Review of the 07/16/25 Annual MDS revealed the resident was independent for daily decision making, had bilateral upper extremity impairment, utilized a wheelchair, and was dependent for personal hygiene. The resident had a plan of care dated 07/23/25 Activity of Daily Living Self Care Performance Deficit related to Chronic Obstructive Pulmonary Disease, disc degeneration, contractures, weakness, and impaired mobility. He will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. The resident has limited physical mobility related to contractures of bilateral upper extremities. Requires moderate to maximum assistance with most functional mobility and ADL performance. Declines any splinting or formal range of motion. Will allow staff to perform cleaning and nail trimming only.Observation on 08/11/25 at 1:27 P.M. of Resident #10 revealed bilateral hand contractures. The fingernails on his left hand were long with debris under the nailbeds He did not have a mechanism in place to protect the palms of his hands from the fingernails of his contracted fingers. The fingernails were making and indentation on his palm.On 08/11/25 at 2:48 P.M. interview with LPN #179 verified the resident's contracted fingers, positioned his fingernails to dig into his palm. Further verified the fingernails were long and soiled.3. Review of Resident #19's medical record revealed a 07/17/24 readmission with diagnoses including lymphedema, dysphasia, anemia, proximal atrial fibrillation, acquired absence of left toes, chronic kidney disease stage three, venous insufficiency, chronic diastolic congestive heart failure, hyponatremia, hyperlipidemia, benign prostate hyperplasia, bladder neck obstruction, type two diabetes, severe protein calorie malnutrition, vitamin D deficiency, chronic respiratory failure, chronic kidney disease and disorder, Parkinson's disease and major depressive disorder. The resident had a plan of care dated 03/25/24 Activity of Daily Living (ADL) self care deficit related to impaired mobility, impaired balance, chronic abdominal wound, diabetic mellitus, morbid obesity, Parkinson's, chronic respiratory failure and Bell's Palsy.Review of the 06/10/25 Quarterly Minimum Data Set Assessment revealed the resident was independent for daily decision making, had bilateral lower extremity functional

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on staff schedule review, payroll-based journal review, facility assessment review, policy review and interview, the facility failed to ensure adequate staffing to meet the needs and staffing as identified in the facility assessment. This had the potential to affect all residents residing within the facility. The census was 68. Findings Include: Review of the Facility Assessment Tool revised 03/24/25 revealed the facility average daily census was 69 to 78 residents. The facility staffing plan was based on the resident population and their varying needs for care and services, the general approach to help the facility gauge sufficient staff to assist in meeting the needs of the residents at any given time involves various factors including: The range of facility staff that may be needed to gauge sufficient qualified staff available to meet each resident's needs may be based on resident AOL acuity, medical complexities, behavioral/psychosocial needs of the residents, and the ebb and flow of day/night routine needs to name a few. This data can be obtained from sources such as the MOS, clinical observations, chart/physician order review, various facility reports, collaboration with other vendors/services such as therapy, behavioral/mental health, and direct care staff input to name a few. The facility may adjust positions and staffing needs as necessary to meet the needs of an aggregate of residents or the overall resident population at any time. Estimated range of licensed nurses providing direct care staff was three to four on day shift and two to three on night shift. Nurse Aides required was five to eight on day shift and four to six on night shift. Other licensed nursing personnel (e.g. those with administrative duties included the DON, ADON and unit manager). Determination of staff assignments can involve many factors such as the number of residents on each hall/unit/community, AOL acuity, medical complexities, specialty community, load of medication/treatment administration, behavioral/psychosocial needs, observations, and staff input. The facility encourages direct care staff to work in one or two areas of the facility for continuity of care and services. Those staff that float throughout the facility tend to desire a change in routine and are more flexible with care and services. Review of staff assignments is an ongoing process as resident conditions change, admissions, discharges, and changes in overall resident population. Changes may occur by shift, day, week or month as the resident population can change very quickly. Review of the second quarter (2025) Payroll-Based Journal revealed the facility had low weekend staffing, did not meet the criteria for registered nurses daily for eight consecutive hours and had a one-star rating for staffing. Review of the Staffing Schedules and Detailed Hour/Time Punch Detail reports dated January 2025 through August 2025 for the below dates revealed the following licensed staffing shift needs were not met: a. No fourth Certified Nurse Aide (CNA) on 02/09/25 between 11:00 P.M. and 3:00 A.M.b. No fourth CNA on 03/08/25 between 7:00 P.M. and 3:00 A.M.c. No third Licensed Nurse on 03/29/25 between 3:00 P.M. and 7:00 P.M.d. No fourth CNA on 04/20/25 between 7:00 P.M. and 5:00 A.M.d. No third Licensed Nurse on 06/16/25 between 3:30 P.M. and 7:00 P.M b. No second Licensed Nurse on 06/22/25 between 7:00 P.M. and 11:00 P.M.c. No fourth CNA on 08/06/25 between 12:00 A.M. and 3:00 A.M. During the course of the survey between 08/11/25 and 08/21/25, interview with five employees who wish to remain anonymous stated there was not enough staff to meet the needs of the residents timely. On 08/11/2025 between 1:54 P.M. to 2:04 P.M., interview with Resident #46 revealed the facility does not have enough staff on the weekends of both nurses and nurse aides. Resident #46 stated she used to be a Certified Nurse Aide (CNA) and knows what they should be doing. Resident #46 stated she can do most things for herself but there are those at the facility that cannot. On 08/12/25 at 6:34 A.M., interview with CNA #185 stated the facility does not always have adequate staffing and if someone call offs, management does not come in to cover. The staff working just does the best they can. There is not always a housekeeper on the weekends and rooms do not get cleaned. On 08/12/25 at 6:59 A.M., interview with CNA #112 stated the facility runs short of help frequently and depending on who is working determines if things all get done or not. Management does not come in to help and staff try to do room checks every two hours but sometimes they are late. On 08/12/25 between 9:05 A.M. and 9:24 A.M., interview with Family #204 revealed the facility does not have enough staff to ensure residents are checked frequently. Family #204 stated concerns have been brought to members of the management team and nothing is done. Sometimes call lights are on for 30 minutes without being answered because they are all busy. Rooms are not cleaned and items that need fixed are reported but not fixed timely. Family #204 stated in June 2025 a concern was reported regarding an air conditioner and it was still leaking and had not been fixed. On 08/12/25 at 12:13 P.M., interview with Maintenance Director (MD) #173 revealed the electronic work order system included a 08/05/25 request to hook up a television for Resident

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on payroll-based journal review, staffing schedule review, policy review and interview, the facility failed to provide eight hours of consecutive registered nurse (RN) hours per day. This had the potential to affect all 68 residents residing within the facility. Findings include: Review of the Payroll-Based Journal second quarter 2025 revealed the facility did not meet the requirement of having a RN for eight consecutive hours daily. Review of the Facility Assessment Tool revised 03/24/25 revealed the facility average daily census was 69 to 78 residents. The facility staffing plan was based on the resident population and their varying needs for care and services, the general approach to help the facility gauge sufficient staff to assist in meeting the needs of the residents at any given time involves various factors. Review of the Staffing Schedules dated January 2025 through July 2025 revealed there was no consecutive eight hour RN coverage on the following dates: 01/18/25, 01/19/25, 02/01/25, 02/02/25, 03/16/25, 04/12/25, 04/13/25, 04/19/25, 04/20/25, 04/26/25, 05/04/25, 05/10/25, 05/11/25, 05/18/25, 05/25/25, 06/07/25, 06/08/25, 06/14/25, 06/15/25, 06/22/25, 06/29/25, 07/20/25 and 07/27/25. On 08/13/25 at 8:35 A.M., interview with the Director of Nursing (DON) stated the facility was not able to accept residents with central lines, TPN or orders for IV therapy more than twice a day due to the availability of a RN and/or an IV trained Licensed Practical Nurse. The DON verified the facility currently had the following direct care RN's: one on nights and 2 PRN (as needed) and the facility wound nurse: however, she was currently on a medical leave of absence. On 08/18/25 at 10:05 A.M. interview with the Assistant Director of Nursing (ADON) verified there was no RN coverage for eight consecutive hours on the following dates: 01/18/25, 01/19/25, 02/01/25, 02/02/25, 03/16/25, 04/13/25, 04/19/25, 04/26/25, 05/10/25, 06/07/25, 06/08/25, 06/14/25, 06/15/25, 07/20/25 and 07/27/25. On 08/19/25 at 8:25 A.M., interview with ADON verified there was no RN coverage for eight consecutive hours on 04/12/25, 04/20/25, 05/04/25, 05/11/25, 05/18/25, 05/25/25, 06/22/25 and 06/29/25. On 08/21/25 between 8:32 A.M. and 8:50 A.M. interview with the DON stated there has been a shortage of RN coverage in the past, as well as, currently and the concern was primarily on the weekends. On 08/21/25 at 9:59 A.M., interview with the DON verified the facility continued to be unable to meet the requirement of having a RN for eight consecutive hours per day/seven days a week. The DON stated the facility had done the following trying to find RN's: a facility self-initiated action plan through their quality assurance program to address the need of RN staff earlier this year and had hired two of four RN's interviewed between 01/09/25 and 08/06/25. One Certified Nurse Aide transitioned to an RN position after passing her nursing boards and was scheduled to start on the schedule in September 2025. The facility had posted the RN positions on the company website, social media (unsure which one) and job fairs but have not been able to fill the positions. The DON stated RN's do not want to work in long term care facilities anymore since COVID-19. On 08/21/25 at 1:47 P.M., interview with the Administrator stated the facility did not have a Staffing Policy and the facility uses their budget to determine staffing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, manufacturer review, policy review and interview, the facility failed to maintain a safe and sanitary kitchen. This had the potential to affect all 68 residents that received food from the kitchen. Findings include: 1.On 08/11/25 between 8:20 A.M. and 8:45 A.M., initial observation of the kitchen revealed Dietary Aide #111 and Dietary [NAME] #128 were preparing and serving breakfast meals. Dietary [NAME] #128 was observed serving an omelet that was dark brown and overcooked. Dietary [NAME] #128's hairnet did not encase all of her hair in the front and both sides. Dietary [NAME] #128 verified the above and she stated she was new to the position. Observation of the reach-in refrigerator revealed no temperature was displayed on the thermometer. Water was observed leaking in the same reach-in refrigerator. The reach-in refrigerator contained a gallon of whole milk, 13 glasses of chocolate milk and three additional cafeteria-style trays each containing glasses of apple juice, cranberry juice and fruit punch. The chocolate milk and juice glasses were covered with plastic lids and saran wrap. Water was leaking from the top portion of the reach-in refrigerator onto beverages ready for meal service. The chocolate milk glasses were sitting in water that filled the cafeteria-style trays. A metal serving pan was observed sitting on top of the chocolate milk glasses without any water in it. At the time of the observation, Dietary [NAME] #128 verified the observation and Dietary Aide #111 stated the reach-in refrigerator had been not working correctly for several weeks and had been leaking water. Dietary Aide #111 also verified the thermometer was not working, stated she would let someone know and then positioned the metal serving pan to the back of the shelf stating the pan should catch the leaking water now. Further observations of the kitchen revealed the stove and kitchen hood had heavy grease build-up and dust trendils along the hood, metal piping and fan screening. The dust trendils were long and were observed moving back and forth as the cook was cooking. There was also heavy food debris along the gas pipes, outlets and serving cart beside and behind the stove. The above was verified by Dietary Aide #111 at the time of the observation. On 08/13/25 at 9:25 A.M., interview with Regional Culinary Director #195 verified the stove and kitchen hood grease and dust trendils remained stating it was to be cleaned on today. 2.On 08/11/25 at 12:40 P.M., observation revealed Pest Control Employee (PCE) #197 entered the kitchen without a hat or hairnet. Regional Culinary Director #195 was in the dietary office next to the kitchen entrance doors and was informed of the observation. RCD #195 verified the observation on 08/11/25 at 12:44 P.M. and stated PCE #197 was going to the dry storage room which was on the other side of the kitchen. 3. On 08/14/25 between 7:00 A.M. and 7:52 A.M., observation with Dietary [NAME] #180 of the prep and steam table revealed a red bucket containing water and cloth on the lower shelf of the steam table. Dietary [NAME] #180 tested the quaternary solution in the red bucket and it tested at 150 ppm (parts per million). Observation of the GFS poster labeled Sanitizer Test Procedure that was posted above the prep station revealed the Quaternary should be a 200 ppm test paper reading and test results must be within the range shown. Observation of the dishwash station revealed an 4-plug size electrical box with electrical wires with two sets of red wire nuts/cap remained with one corner resting on the floor under the dishwashing station. There was no cover protecting the electrical wires except for the wire nuts. The above was verified by Dietary [NAME] #180 at the time of the observations and stated maintenance had informed him the electrical wires were no longer in use or connected to electricity. Review of the undated policy: Cleaning Standards revealed food contact surfaces, non-food contact surfaces, equipment, pans and utensils must be kept clean at all times. This includes but not limited to free of grease deposits, food residue, dust and other soil accumulation/debris. Sanitizer buckets to maintain clean equipment and work areas include: sanitizer solution is in appropriate concentration (use test strip to determine this and solution is changed at least every four hours. Production, storage and service equipment to be cleaned and sanitized as required as recommended by the manufacturer. Review of the undated policy: Use and Storage of Digital and Unit Thermometers revealed all thermometers must be used, stored, calibrated and maintained in a manner that ensures accuracy, hygiene, and compliance with safety standards. Faulty or uncalibrated thermometers must be discarded or repaired promptly to prevent risks to resident health and safety. This deficiency represents non-compliance investigated under Complaint Number 2569206.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interviews, and policy reviews the facility failed to ensure enhanced barrier precaution (EBP) were implemented/maintained and infection control practices were maintained during incontinence care. This affected three residents (#1, #32, and #42) of four residents observed on 100-unit for EBP and two residents (#20 and #77) of two residents observed for incontinence care. Findings Include: 1. Medical record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including gastrostomy tube. Review of Resident #32' EBP plan of care dated 07/23/25 revealed to use appropriate EPB when performing the following care: dressing, bathing, showering, transferring, hygiene care, changing linen, toileting, and peri care. Dispose of EBP in the appropriate containers. Review of Resident #32 current orders revealed no evidence of orders for EBP. Interview and observation on 08/11/25 at 10:32 A.M., of Resident #32 revealed the resident had a gastrostomy tube. The resident reported staff flush the tube, however they do not wear gowns when providing direct care or flushing the tube. There was no evidence of EBP sign in the room or personal protective equipment (PPE) outside the room. Interview and observation on 08/11/25 at 11:09 A.M., with Licensed Practical Nurse (LPN) #108 confirmed resident #32 should have been on EBP for her gastrostomy tube. The LPN confirmed if a resident was in EBP there should be a sign in the room above the resident bed, a PPE basket hanging outside the room on the wall, and a signed order for resident on EBP. LPN #108 confirmed Resident #32 did not have a sign or a basket outside the room to alert staff that the resident was in EBP or a signed order. 2. Observation and interview on 08/11/25 at 11:11 A.M., with LPN #108 revealed Resident #42 was in EBP because he had a urinary foley catheter. The LPN confirmed there was no evidence of a sign above the residents' bed nor a basket outside the door. LPN #108 reported the sign was hung above the roommate's bed in error instead of Resident #42's bed and the basket had broken and she had requested a new basket. 3. Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including osteomyelitis, diabetes, bacteremia, and skin alterations. Review of Resident #1's EPB plan of care dated 06/26/25 and revised 08/12/25 revealed to dispose of EBP in the appropriate container, do not use EBP outside resident rooms such as hallways, common areas, and dining rooms, use appropriate EPB when performing the following care: dressing, bathing, showering, transferring, hygiene care, changing linen, toileting, and peri care. Treatment for wounds and utilize proper hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/11/25 at 11:10 A.M., with LPN #108 revealed two Certified Nursing Assistants (CNA's) were providing care to Resident #1 with no PPE in place. Dirty linens were noted on the floor not in a bag. The two CNAs reported to LPN #108 they didn't think they were required to wear PPE since they were not providing wound care. LPN #108 provided education to the CNAs. Interview on 08/11/25 at 11:22 A.M., with LPN/infection preventionist (IP) #179 confirmed resident with EBP should have a sign above the bed, orders, and a basket outside the room with PPE equipment. Review of the facility's policy and procedure titled Enhanced Barrier Precautions (EBP) dated 04/2018 and revised 01/2025 revealed EBP are indicated for residents with any of the following: Infections or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply or wound and indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. For residents who EBP are indicated, EBP is employed when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, hygiene care, changing linens, changing briefs or assisting with toileting, device care, and/or wound care. The gown and gloves used for each resident during high-contact resident care activities should be removed and discarded after each resident care encounter and hand hygiene should be performed. An EBP isolation sign would be placed near the resident's room identifying the PPE required during high contact care activities. 4. Observation on 08/19/25 at 2:00 P.M., of incontinence care with CNA's #100 and #132 for Resident #20 revealed staff had already had the supplies ready and the resident positioned for incontinence care. Staff explained procedure to the residents. The two CNAs unfastened the resident's brief and rolled the brief down between her legs. CNA #100 placed soap on a washcloth and wiped down the middle of labia and then changed positions on the washcloth and then wiped the right outer thigh crease and then the left outer thigh crease. She repeated the procedure for the rinse and dry. The CNA confirmed she did not cleanse the right and left side of the inner labia. CNA #100 reported she was not trained to spread the labia apart and wash both sides of the labia just to cleanse down the center. Review of the skills checklist undated for perineal care revealed to use a soapy washcloth to wash the front perineum to include the genital and skin fold areas of the groin. There were no instructions on how to cleanse the perineal area. Review of the incontinence care policy 04/18 and revised 01/06/25 revealed to clean area with perineal wash or with mild cleanser and pat dry. There were no instructions on how to cleanse the perineal area. Interview on 08/19/25 at 3:11 AM with the LPN/IP #179 reported the perineal care skilled checklist did not include detail instruction on how to cleanse the perineum area. Interview on 08/20/25 at7:22 A.M. with the Director of Nursing (DON) confirmed the policy and competency did not include specific instructions on how to cleanse the perineal area. The DON reported her expectation would be the labia should have been cleansed in the middle and then the labia should have been spread apart and cleansed right and then left. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Medical record review revealed Resident #77 had multiple admissions to the facility and was most recently admitted on [DATE] with diagnoses including peripheral arterial disease, diabetes mellitus, bilateral below the knee amputations (BKA) and multiple wounds. Review of the census revealed the resident was discharged to the hospital on [DATE] with a diagnosis of encephalopathy and returned to the facility on [DATE]. Review of the Wound Care re-consultation visit for wound care services dated 08/14/25 revealed multiple wounds including a Stage III pressure ulcer to the coccyx present on admission measuring 3.5 (cm) in (l) by 4.9 (cm) in (w) by 0.2 (cm) in depth (d). The wound bed was 100% granulation with scant serous drainage. Education was provided on the importance of offloading to promote wound healing and maintaining proper hygiene to support wound healing including to keep the wound site clean and dry, avoiding contamination and the importance of adhering to prescribed treatments and dressing changes to prevent infection was emphasized. On 08/19/25 between 4:15 P.M. and 5:01 P.M., observation of incontinence care revealed licensed practical nurse (LPN) #131 and certified nursing aide (CNA) #107 were observed washing their hands and applied gloves. CNA #107 gathered incontinence supplies, positioned the resident in bed and removed the tape from the incontinence brief. The resident was observed to have been incontinent of urine and CNA #107 washed the resident's penis, groin and up under the scrotum. LPN #131 and CNA #107 rolled the resident onto his left side exposing the buttock and coccyx. An unstageable pressure ulcer irregular in shape was observed to be 75% covered with slough with scant drainage. CNA #107 proceeded to cleanse the groin under the scrotum, and wiped across the rectum and over the lower aspect of the Stage III pressure ulcer. CNA #107 then using the same gloved hands grasped a clean wash cloth and rinsed the resident in the same order. CNA #107 and LPN #131 rolled the resident over onto his right side and LPN #131 using the same gloved hands placed her thumb on various areas of the peri-wound and wound center then applied triad cream around the wound perimeter but not the wound bed. The resident was then repositioned on his back, incontinence brief applied and head of bed raised to 30 degrees. LPN #131 removed her gloves, washed her hands and stated she was going to notify the physician of the wound due to a change in the appearance of the wound. CNA #107 changed the linens on the resident's bed and then removed her gloves and washed her hands. CNA #107 verified the above observation on 08/19/25 at 4:45 P.M. and LPN #131 verified the above observation on 08/19/25 at 5:01 P.M. and stated she had messaged the physician and was awaiting a response. This deficiency represents non-compliance investigated under Complaint Number 2583878, 2588814, 2569206.

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	08/21/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. (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	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Willow Haven	1020 Taylor Street Zanesville, OH 43701

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, record review, review of manufacturer guidelines and interview, the facility failed to ensure an exit door, clothes dryer, air conditioner and refrigerator were maintained. This had the potential to affect all 68 residents in the facility. The census was 68.Findings Include:1.Review of an elopement investigation dated 05/19/25 revealed the facility determined the 100 hall door was not locked as the key panel indicated.Interview on 08/21/25 at 8:51 A.M. with Maintenance Staff #173 revealed the 100 hall exit door is an Advantage 500 DE System. It was not connected to a Wanderguard system. The door at the end of the 100 hall had a key pad. The door was hardwired with a battery back up. The doors had a red and green light on the keypad. Red means locked and green open. The door was pushed to see if it opened during weekly door checks. Prior to the elopement the door was last checked on 05/15/25. Maintenance Staff #173 said the day of the elopement the door keypad was showing red. However, when the door was pushed, it opened. He said they looked and the back up battery was corroded. (The battery was last changed 11/20/24). It must have still had enough power to make the light red but not enough for the magnet to lock the door. Also, the electricity to the door failed. They had been trying to find out why the door wasn't consistently working. They were getting another used part in this Friday, three months and three days since the elopement. They had been conducting daily door checks since the elopement.Review of the Installation Manual for Advantage 500 DE System dated 05/16/11 revealed on page 6 only a Qualified Service Technician should work on Secure Care System. Secure Care does not authorize, and strongly recommends against, any installation or field replacement of software, parts or products by untrained contractors or facility staff. Such work can be hazardous, can render the system ineffective and will void any Secure Care warranty or liability that might otherwise relate to the system. Page seven included Warning: even slight modifications to the system or changes in the operating environment may cause secure care's system to malfunction, The only way to assure that secure care's system has been installed, set up, tested, supported, maintained and repaired correctly is to have a qualified service technician do the work.Interview on 08/21/25 at 12:21 P.M. with Regional Maintenance #200 revealed initially the corroded battery was replaced on 05/19/25. The door alarmed and locked. On 05/22/25 the door opened when checked even though the red light was on. Maintenance #200 said he had a transformer for the magnetic box on top of the door. He replaced the transformer and the door locked for about a month (06/20/25) and then the door was found to open again even though it indicated alarmed with a red light on the door. He then replaced a transformer in the ceiling with a stronger one that went to the key box. The door had been locked since. The door was in emergency mode. It runs off the 9 volt battery and converts it to a 12 volt. The doors were also on a generator. It was riding on the battery temporary. When staff did the checks it was operating off of the battery. He had changed two transformers because they were getting weak. He was getting in a used Printed Circuit Board (PCB) part coming this Friday. He verified he was not a Qualified Secure Care Technician. He said he could call a technician but believed he knew how to fix the door even though if had been over three months since the incident. He had not had an outside entity come in to check the door. 2.Interview on 08/12/25 at 12:15 P. M. with Laundry/Housekeeping #140 revealed the laundry only had one functioning dryer prior to the fire. She stated a load of laundry was dried half at a time. So, the wash was not able to be dried all at once. She indicated if the air conditioning worked in the laundry it was very little.Interview on 08/21/25 at 11:32 A.M. with Maintenance #173 included the second dryer in the laundry had been broken since October 2024. He looked at it to see what was wrong with it. The dryer was not getting power. The dryer was so old that Regional Maintenance #200 told him they could not find the part. He did not know why the facility hadn't bought another. He verified the air conditioning had not been working since he arrived two years prior. It was set up for central air and the system was too old to get a new part.Interview on 08/21/25 at 1:55 P.M. with the Administrator revealed she thought they were trying to get parts for the clothes dryer. She included she thought the second dryer and air conditioner had not worked since she started a couple years ago. She included she had not tried to order a new dryer. 3.On 08/11/25 between 8:20 A.M. and 8:45 A.M., observation of the reach-in refrigerator revealed water was leaking in the same reach-in refrigerator that included a gallon of whole milk, 13 glasses of chocolate milk and three additional cafeteria-style trays each containing glasses of apple juice, cranberry juice and fruit punch. The chocolate milk and juice glasses were covered with plastic lids and saran wrap. Water was observed on top of the chocolate milk lids and the glasses were sitting in water that filled the cafeteria-style trays. A metal serving pan was observed sitting on