

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 12/04/2025
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 12/04/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, interview and review of facility's medication administration policy, the facility failed to ensure medical records were accurate and complete regarding the administration of controlled substances. This affected two (Resident #55 and #56) of 25 residents reviewed for medication administration. The facility census was 74. Findings include:1. Review of the medical record for Resident #56 revealed an admission date of 04/08/25 with diagnoses including diabetes mellitus, chronic obstructive pulmonary disease, weakness, acquired absence of left leg above knee, muscle weakness, depression, and chronic kidney disease.Review of the care plan dated 09/09/25 revealed the intervention to give analgesics as ordered by the physician and to monitor/document for side effects.Review of a physician order dated 10/31/25 revealed the order for Hydrocodone-Acetaminophen 5-325 milligrams (mg) (opioid pain medication) one tablet by mouth every eight hours as needed for moderate to severe pain.Review of Resident #56's Individual Patient Controlled Substance Administration Record revealed Hydrocodone-Acetaminophen 5-325 mg one tablet was administered on 11/19/25 at 10:50 P.M. Review of Resident #56's Medication Administration Record (MAR) revealed no documentation of the administration of Hydrocodone-Acetaminophen 5-325 mg, one tablet, on 11/29/25 at 10:50 P.M. There was a discrepancy between the Controlled Drug Record and the MAR.Observation of medication cart on 12/04/25 at 10:35 A.M. with Registered Nurse (RN)/Unit Manager #134 confirmed Resident #56's MAR did not contain documentation of the administration of Hydrocodone-Acetaminophen 5-325 mg, one tablet, on 11/29/25 at 10:50 P.M.Interview on 12/04/25 at 10:35 A.M. with the Assistant Director of Nursing (ADON) confirmed Resident #56's Individual Patient Controlled Substance Administration Record revealed Hydrocodone-Acetaminophen 5-325 mg one tablet was administered on 11/19/25 at 10:50 P.M.; however, his MAR revealed no documentation of the administration of Hydrocodone-Acetaminophen 5-325 mg, one tablet, on 11/29/25 at 10:50 P.M. The ADON stated the facility would follow up with the nurse who failed to document the medication administration on the MAR.2. Review of the medical record for Resident #55 revealed an admission date of 08/06/21 with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type two diabetes mellitus, transient cerebral ischemic attack, hypertension, pain, unspecified, other chronic pain, atrial fibrillation, hypothyroidism, and hyperlipidemia. Review of the care plan for Resident #55 revealed an intervention to administer all medications as ordered. Review of the November 2025 MAR of Resident #55 revealed an order for Oxycodone HCl oral tablet 5 mg (opioid pain medication) give half a tablet by mouth three times a day for breakthrough pain. Review of the MAR revealed the Oxycodone was given on 11/10/25 for the bedtime dose but was marked as an error on the narcotic count sheet. Additionally, two narcotic sheets titled Individual Patient Controlled Substance Administration Record-30 dose for Resident #55 had no date of the narcotic received, no amount of the narcotic, no amount sent of narcotic, and no signature of the person receiving the narcotic. Interview on 12/04/25 at 11:36 A.M. with Licensed Practical Nurse (LPN) #136 verified there was a 11/10/25 bedtime dose of Oxycodone for Resident #55 which was marked as given on the MAR and not signed out on the narcotic count sheet. LPN #136 verified there was no signature for when the narcotics were received, no date received, no amount received, no amount sent for two of the narcotic sheets for Resident #55. Interview on 12/04/25 at 12:26 P.M. with the ADON confirmed the 11/10/25 bedtime dose of Oxycodone for Resident #55 was given per the MAR, but the narcotic count sheet had the Oxycodone crossed out in error which would indicate the Oxycodone was not given. Additionally, the ADON confirmed there was no received signature, no date received, no amount received, and no amount sent on two drug narcotic count sheets for Resident #55. Review of the facility policy Controlled Medication Storage and Accountability, dated 04/2018, a controlled medication accountability record is prepared when receiving inventory of a Schedule II medication. Accountability record necessity for Scheduled III, IV, or V medications will depend on state regulations or decision of the center. The following information is completed: name of resident, prescription number, name, strength (if designated), and dosage form of medication, date received, quantity received, and name of person receiving medication. At each shift change or when keys are transferred, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented of the controlled substances accountability record or verification of controlled substances count report. Any discrepancy in controlled substance medication counts is reported to the Director of Nursing (DON) immediately. The DON or designee investigates and makes every reasonable effort to reconcile all reported discrepancies while nurses remain on duty. The DON in a</p>		