

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  12/30/2025
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 0610  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Respond appropriately to all alleged violations.  (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
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, review of a self-reported incident, facility investigation review, interview and policy review, the facility failed to complete a thorough investigation related to an allegation of misappropriation. This affected one resident (#78) of three residents reviewed for misappropriation. The facility census was 76. Findings include: Review of the medical record for Resident #78 revealed an admission date of 08/14/25 with diagnosis including chronic obstructive pulmonary disease, anxiety disorder anemia, hypothyroidism, depression, chronic respiratory failure, and dependence on supplemental oxygen. Review of the resident's personal inventory from admission did not include an Apple watch. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14 out of 15 points, which indicated intact cognition. Review of Self-Reported Incident (SRI) Tracking Number 266105 and facility investigation dated 10/07/25 revealed the category of the allegation was misappropriation. The SRI revealed Resident #78 had stated her Apple watch was missing from her room. Additionally, employee statements which indicated multiple employees had seen the Apple watch in Resident #78's room prior to 10/07/25. One of the employee statements revealed Resident #78 had a locator app on her cell phone to track the Apple watch. Resident #78 had been in the local hospital on [DATE] and 09/30/25 and returned to the facility on [DATE]. The SRI also stated the facility was doing laundry off site during the timeframe of the watch being reported missing. Furthermore, the investigation did not contain documentation of communication with the hospital staff to determine if Resident #78 left her Apple watch at the hospital. There was also no evidence the off-site laundry services were contacted to determine if the watch was found in laundry from the facility. Further review revealed no evidence the resident's location app was used to track her watch and no documentation to support police involvement and lastly, no evidence of interviews with like residents or residents who live on the same unit as Resident #78 to determine if they had knowledge of anything with the watch or if they had been impacted by allegations of misappropriation. Review of an instant message dated 10/07/25 at 1:30 P.M., and printed from the Administrator's computer during the onsite survey, revealed she had sent communication to the laundry service regarding Resident #78's missing Apple watch but there was no evidence of follow-up communication. Review of the missing items log for the month of October 2025 revealed Resident #78's Apple watch was not on the missing items log. Interview on 12/30/25 at 2:07 P.M. with the Administrator revealed she was not sure if Resident #78's son called the police or not but confirmed no police had come to the facility regarding Resident #78's missing Apple watch. The Administrator stated the Apple watch was not on Resident #78's inventory of personal effects. The Administration verified that staff do not always update the inventory of personal effects when a resident receives a new item. The Administrator stated they did try the locator app on Resident #78's phone, but the watch must have been dead, and they could not locate the watch and verified there was no documentation to indicate they had checked the app locator on Resident #78's phone. The Administrator verified there was no documentation of communication with hospital staff regarding the resident's missing watch and no statements from other residents, especially residents who lived in the same area to determine if they had knowledge of the missing watch or if they had missing items. Review of the facility abuse policy dated as reviewed on 05/2025 stated residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. Additionally, the investigation section of the facility abuse policy dated as reviewed on 05/2025 stated the person investigating the incident should generally take the following actions: interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. If there are no direct witnesses, then the interviews may be expanded. If the allegation involves abuse/neglect, interview other residents, as appropriate, to determine if they may have been affected by the accused staff member or resident. Interview other health care professionals, as appropriate, and document all interviews. Review all relevant medical reports/records, as applicable. Evidence of the investigation should be documented in accordance with Quality Assurance (QA) protocols. Furthermore, the follow up section of the facility abuse policy dated as reviewed on 05/2025 stated whether the incident/allegation is substantiated or unsubstantiated the Administrator and/or Director of Nursing (DON) or designees will ensure involved resident's plan of care is reviewed and revised, as appropriate, consistent</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observations, review of purchase order history and interviews, the facility failed to ensure water temperatures in the shower rooms were at the appropriate temperature. The facility also failed to ensure a shower, sink, exhaust fan, and ceiling light were working appropriately and in good repair. This had the potential to affect 56 residents residing on Units 200, 300, 400 and 500. Facility census was 76. Findings include: Review of the printed orders from Amazon, provided by Maintenance Direct #295, revealed a shower valve was ordered to replace a bad valve for the 200-hall shower room on 11/12/25. An additional order dated 12/02/25 revealed a vacuum breaker was ordered for the 200-hall shower room. An observation on 12/30/25 at 8:57 A.M. revealed there was no water when the hot water handle in the sink in the 400-hall shower room was turned on. An interview on 12/30/25 at 8:59 A.M. Certified Nursing Assistant (CNA) #246 verified the shower room on the 200-hall sprayed water out of the pipes and was not working properly so residents requested to be showered on the 400 or 500 halls. CNA #246 verified the water temperature in the shower rooms on the 400 and 500 halls were always cold. An observation on 12/30/25 at 8:59 A.M. of the 200-hall shower room revealed a medical glove over the pipes coming out of the wall and went to the shower head. Water was observed dripping into the glove even though the shower was turned off. An interview on 12/30/25 at 9:00 A.M. Maintenance Director #295 verified parts had been ordered and delivered for the 200-hall shower room, but he did not have time to fix the shower and wasn't sure when the repairs would be done because he also had other repairs to complete. Maintenance Director #295 stated at first the shower on the 200-hall did not have hot water, so a shower valve was ordered. Then water started spraying out of the pipes coming out of the wall, so another part was ordered on 12/02/25. An additional interview and observation at 9:55 A.M. with Maintenance Director #295 verified the ceiling exhaust fan cover was missing and there was clear liquid that appeared to be water and brown colored stains in the ceiling light cover in the 200-hall shower room. Maintenance Director #295 verified he did not check water temperatures in the shower rooms. An interview on 12/30/25 at 10:00 A.M. Maintenance Director #295 verified there was no water when the hot water was turned on in the sink in the 400-hall shower room. An interview on 12/30/25 at 10:20 A.M. Maintenance Director #295 verified the water in the 400-hall shower room was 101 degrees Fahrenheit (F) and was not at an appropriate temperature for residents to use for bathing/showers. An interview on 12/30/25 at 10:25 A.M. Maintenance Director #295 verified the water in the 500-hall shower room was 102 degrees F and was not at an appropriate temperature for resident use for showers. This deficiency represents non-compliance investigated under Complaint Number 2692752.</p>		