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	04/06/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to ensure a resident representative was notified of a change in condition. This affected one resident (Resident #7) of eight residents reviewed for notification of change. The facility census was 69.Findings include: Record review revealed Resident #7 re-admitted to the facility on [DATE] with diagnoses including epilepsy, dementia, chronic kidney disease, pressure ulcer of left buttock, transient ischemic attack, anxiety, major depressive disorder, hypertension, and dysphagia (difficulty swallowing).Review of Resident #7's progress note dated 02/20/26 at 2:04 P.M. revealed Resident #7 complained of pain to the right nephrostomy tube insertion site. Area continues to be warm to touch, red in color and small amounts of drainage noted. Preliminary lab results of the nephrostomy tube site received. Med one notified of same, new orders received for doxycycline (antibiotic) 100 milligram (mg) twice a day (BID) for seven days. Resident notified of same and agrees with new orders. Call light and fluids in reach.Review of Resident #7's record revealed no documentation of the resident's Power of Attorney (POA) being notified of the resident's change in condition and new orders on 02/20/26.Record review revealed a progress note dated 02/22/26 at 9:15 A.M. revealed Resident #7's wound culture (from the right nephrostomy tube insertion site obtained on 02/19/26) resulted positive for methicillin- resistant staphylococcus aureus (MRSA) and the resident was placed on contact isolation precautions for seven days.Review of Resident #7's record revealed no documentation of the resident's Power of Attorney (POA) being notified of the resident's change in condition (positive culture for MRSA and contact precautions) on 02/22/26.Review of Resident #7's quarterly Minimum Data Set (MDS) Assessment completed on 03/04/26 revealed a brief interview for mental status (BIMS) score of 08 indicating moderate cognitive impairment. Further review revealed the resident was dependent for toileting, showering, transfers, and mobility.Review of Resident #7's progress note dated 03/05/26 at 9:36 A.M. revealed the resident's indwelling urinary catheter was changed per request due to the resident complaining of lower abdominal pain and lower back pain. #18 French indwelling urinary catheter was placed. 550 milliliters of urine retrieved from the catheter after the change, urinalysis sent and nurse practitioner aware.Review of Resident #7's medical record revealed no documentation of Resident #7's POA being made aware of the resident's change in status on 03/05/26.Interview on 03/18/26 at 8:00 A.M. with Resident #7 revealed the resident wanted his daughter (POA) notified of changes and the facility should know this as it should be in the record. Interview on 03/17/26 at 8:13 A.M. with Nurse #95 revealed if there was a new medication order or change in condition, the staff would notify the resident's representative if the resident was not alert and oriented. Nurse #95 stated Resident #7 had a daughter who was his POA and was very involved in making decisions. Nurse #95 verified the resident's POA should have been notified of his new medication orders and change in condition but was not notified.Review of facility policy reviewed June of 2025 titled Notification of Change in Condition revealed the nurse will inform the resident, resident's physician, and if known notify the resident's legal representative or resident representative when there is a significant change in the resident's physical, mental, psychosocial status and need to alter treatment including (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 04/06/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Willow Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Taylor Street Zanesville, OH 43701	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinuing existing form of treatment due to adverse consequences, or to commence a new form of treatment, and abnormal lab results. Upon notification of the resident, physician and if known the resident's legal representative or resident representative documentation will be entered into the resident's record reflecting exchange of information.This deficiency represents non-compliance investigated under Complaint Number 2707660.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure meal intakes were monitored and recorded for every meal, as per the plan of care. This affected three (Resident #7, #8 and #71) of three residents reviewed for nutrition/ weight loss. Findings include: 1.Review of Resident #7's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, epilepsy, hallucinations, delusional disorder, anxiety disorder, major depressive disorder, muscle wasting and atrophy, constipation, anemia, hyperlipidemia (high cholesterol) dysphagia (difficulty swallowing),and a history of a traumatic brain injury. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had minimal difficulty hearing and clear speech. He was able to make himself understood and was able to understand others. His cognition was moderately impaired and mood indicators were present to include a poor appetite. His height was 75 inches, but no weight had been recorded, and any history of a significant weight loss (SWL) was unknown at the time. Review of Resident #7's care plans revealed he had an active care plan in place for being at risk for malnutrition that originated on 04/03/25. He had a history of an unplanned SWL due to refusals of meals when having UTI's. He had refused all facility supplements when attempted and was refusing to be weighed more frequently. The goals were for the resident to consume adequate energy to avoid significant, unplanned weight changes and for his intake to remain at least 50-75% of most meals. The interventions included the need to monitor and evaluate his meal percentage intake via meal intake records and observation.Review of Resident #7's physician's orders revealed he was to receive a regular diet, with regular texture, and thin liquids. He was also receiving Remeron 15 milligrams by mouth every night for the treatment of depression and to help stimulate his appetite. Review of Resident #7's recorded weights revealed he has had a SWL as his weights had reduced from 190 pounds on 10/08/25 to 175 pounds on 04/02/26. He had refused to be weighed in the months of February and March 2026 resulting in his SWL not being identified until he agreed to be weighed on 04/02/26. Review of Resident #7's meal intakes recorded for the past 30 days (03/10/26- 04/06/26) revealed not all three meals served each day were being recorded under the point of care history for amounts eaten in the electronic medical record (EMR) under the task tab. There were no meals recorded for any of the three meals served to the resident on 03/20/26, 03/22/26, 03/26/26, or on 03/27/26. Only one of three meals served to the resident were recorded on 03/25/26 and 04/05/26. Only two of the three meals served to the resident were recorded on 03/11/26, 03/13/26, 03/18/26, 03/19/26, 03/21/26, 03/29/26, and 04/03/26. Only 14 of those 30 days were all three meals recorded that had been served to the resident to reflect the amount of the meal that he had consumed. 2.Review of Resident #8's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included central cord syndrome at unspecified level of the cervical spine, post-laminectomy syndrome, cervical disc disorder w/ myelopathy, chronic obstructive pulmonary disease, anxiety disorder, Vitamin D deficiency, nutrition deficit, muscle weakness, pain, constipation, muscle spasms, depression, anemia, and hemiplegia and hemiparesis following CVA (stroke) affecting left non-dominant side. Review of Resident #8's significant change MDS assessment dated [DATE] revealed the resident had adequate hearing and clear speech. He was able to make himself understood and was able to understand others. His cognition was moderately impaired. He was dependent on staff for eating. His height was 66 inches and his weight was 119 pounds. No known SWL was noted and he was indicated to be on a therapeutic diet.Review of Resident #8's active care plans revealed the resident had a care plan in place for being at risk for malnutrition. He was known to have a SWL of 7.2 pounds/ 5.4% loss from his hospital weight likely due to fluid fluctuations. He was not accepting supplementation and the facility was trying a Magic Cup for the resident. The (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions included the need to monitor his intake and record every meal.Review of Resident #8's meal intakes for the past 30 days (03/08/26- 04/05/26) recorded under the task tab of the EMR revealed not all meals served to the resident were being recorded in the medical record. No meal intakes were recorded for any of the three meals served on 03/12/26, 03/23/26, and 04/05/26. Only two of the three meals were recorded on 03/08/26, 03/11/26, 03/15/26, 03/18/26, and 03/29/26. On 04/06/26 at 12:02 P.M., an interview with Regional Clinical Support #500 indicated it was expected that the nursing staff recorded the amount of a meal a resident ate for all three meals served that day. He did not provide any documentation for the resident's missing intakes for the missing meals indicated above. 3.Review of Resident #71's medical record revealed he was admitted to the facility on [DATE]. He remained in the facility until his discharge on [DATE]. His diagnoses included unspecified dementia, a history of a stroke, adult-onset diabetes mellitus, depression, unspecified protein-calorie malnutrition, muscle weakness, difficulty walking, gastroesophageal reflux disease, and constipation. Review of Resident #71's admission MDS assessment dated [DATE] revealed he had no communication issues and his cognition was moderately impaired. Set up/ clean up assistance with eating. His height was 68 inches and his weight was 175 pounds. He was not known to have had a SWL. Review of Resident #71's active care plans revealed he had a care plan in place for being at risk for malnutrition. The care plan was initiated on 12/30/25. The goals were for the resident to maintain his weight and to consume at least 50- 75% of most meals. The interventions included the need to monitor his intake and record every meal. Review of Resident #71's physician's orders revealed he was on a carbohydrate controlled diet with regular texture and thin liquids. He was to be up in his chair for all meals.Review of Resident #71's meal intakes recorded from 12/30/25 thru 01/17/26 revealed the facility staff were not consistently recording the percentages of meals the resident was consuming. None of the three meals served to the resident were recorded on 01/02/26, 01/09/26, 01/11/26, or 01/16/26. Only one of three meals served were recorded for 12/31/25, 01/03/26, 01/04/26, 01/12/26, and 01/17/26. Only two of three meals served were recorded on 01/01/26, 01/08/26, and 01/15/26. There were only seven days where all three meals had been recorded to reflect what percentage of the meal the resident consumed, while he was in the facility. On 04/06/26 at 4:30 P.M., an interview with the facility's Administrator and Regional Clinical Support # 500 confirmed meal intakes were not consistently being recorded to reflect the percentage of the meal each of the three residents consumed for all three meals served each day. No additional meal intakes were provided to show evidence the residents' plan of cares were being followed in regards to the recording of meal intakes for each meal served. Review of the facility's policy on Nutritional Documentation Guidance last reviewed in June 2025 revealed daily meal documentation was to be completed by the facility's direct care staff. Under the documentation guidelines, the nursing assistants or the licensed nurses were to observe meal intakes and document them in the facility's computer software program (PointClickCare) under the point of care. The following deficiency was issued relative to incidental findings that were discovered during this complaint investigation completed on 04/06/26.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on closed record review, interview, and policy review the facility failed to prevent significant medication errors. This affected one resident (Resident #72) of eight residents reviewed for medications. The facility census was 69.Findings include: Review of Resident #72's closed medical record revealed an admission date of 02/26/18 and discharged on 12/24/25 with diagnoses including type 2 diabetes, major depressive disorder, anxiety, blindness of one eye, cognitive impairment and chronic obstructive pulmonary disease.Review of Resident #72's physician orders revealed an order dated 12/16/25 for lorazepam (antianxiety medication also known as Ativan) oral tablet 0.5 milligram (mg) give 0.5 tablet (the order was to give 0.5mg 1/2 tablet) by mouth every eight hours as needed for anxiety for 14 days. Target behaviors of restless, yelling out, combative.Review of Resident #72 care plan dated 09/20/23 and revised 04/10/25 revealed the resident had a behavior problem. Interventions include administration of medications as ordered. The resident uses anti-anxiety medications related to anxiety disorder, interventions include administration of anti-anxiety medications as ordered by the physician.Review of Resident #72 medication administration record (MAR) for December 2025 revealed lorazepam oral tablet 0.5 milligram (mg) give 0.5 tablet by mouth was ordered and documented as administered by Registered Nurse (RN) #401 on 12/16/25 at 9:18 P.M. Review of Resident #72's progress note dated 12/17/25 at 5:26 A.M. authored by nurse #401 revealed the nurse recognized, at that time, a medication error was made with lorazepam. Review of Resident #72's progress note dated 12/17/25 at 5:27 A.M. authored by Assistant Director of Nursing (ADON) revealed Nurse #401 notified ADON of medication error regarding Resident #72 receiving 0.5mg of Ativan (lorazepam) instead of 0.25 mg.Interview on 03/17/26 at approximately 2:15 P.M. with the ADON confirmed Nurse #401 administered the wrong dose of lorazepam to Resident #72 as she administered 0.5 mg of lorazepam instead of 0.25 mg (half of a 0.5 mg tablet). Two attempts were made during the onsite investigation to reach RN #401 however; no return contact was provided.Review of undated facility policy titled Medication Administration revealed prior to and during administration, the nurse must observe the five rights of medication administration the right patient, right dose-verify the dosage on the medication administration record, check the doctor's original order if there is a concern or question, right time, right route, right drug.This deficiency represents non-compliance investigated under Complaint Number 2707660.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on record review, observation, interview, and policy review the facility failed to ensure residents received diets per orders to meet the resident's needs. This affected one resident (Resident #7) of three residents reviewed for nutrition. The facility census was 69.Findings include:Review of Resident #7's medical record revealed a re-admission date of 02/08/25 with diagnoses including epilepsy, dementia, chronic kidney disease, pressure ulcer to the left buttock, anxiety, major depressive disorder, and dysphagia (swallowing difficulty). Review of Resident #07 orders revealed an order placed on 02/03/26 for large protein portions at meals, cut meats/ entrees to bite sized for wound healing.Review of Resident #7's quarterly Minimum Data Set (MDS) Assessment completed on 03/04/26 revealed a brief interview for mental status (BIMS) score of 08 indicating moderate cognitive impairment. Further review revealed the resident was dependent for toileting, showering, transfers, and mobility. The resident also required set up/clean up assistance for eating.Review of Resident #7 at risk for malnutrition and or dehydration care plan related to a past medical history of seizures, dementia, stage 3 chronic kidney disease, dysphagia, history of unplanned significant weight loss, refusal of facility supplementations, intakes and weights fluctuating significantly, frequently poor appetite, refusals of weights with large protein portions to ensure high protein intakes, the resident has had multiple episodes of skin breakdown so high protein diet to guard against reoccurrences. Strongly refuses Juven, Prostat, supplementation was dated 02/08/26 Interventions included monitoring and evaluating meal percentage intake via meal intake records and observations, provide meals per physician diet orders, provide feeding and dining assistance as needed.Interview on 03/18/26 at 8:00 A.M. with Resident #7 revealed he had concerns with the dietary department. The resident shared the kitchen was always messing up his food and it doesn't seem like anyone cares to do anything about it. Resident #7 stated it was hard for him to eat some foods because he doesn't have teeth. Further interview revealed the resident told the staff what he liked and didn't like to eat and it would be on his meal ticket but the facility still served the wrong stuff. Observation of the breakfast meal on 03/18/25 at 8:24 A.M. revealed Resident #7 was served a tray with one piece of ham (whole), one piece of bread and a small portion of scrambled eggs. Review of the resident's meal ticket, located on his breakfast tray, stated cut food into bite sized pieces highlighted in pink and the ticket also indicated large protein portions.On 03/18/26 at 8:24 A.M. interview with certified nursing assistant (CNA) #33 confirmed the resident's meal ticket said the resident's food was to be cut into bite sized pieces and contain large protein portions however, the resident's ham and bread were not cut into bite sized pieces and the resident didn't receive large portions of his protein which was ham and eggs. Review of facility policy titled Portion Sizes dated September 8th of 2021 revealed large portions are one and a half times the standard portion unless otherwise indicated on the meal ticket. The following deficiency was issued relative to incidental findings that were discovered during this complaint investigation completed on 04/06/26.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure medical records were complete and accurate when the nursing staff failed to document the continency status and meal consumption percentages of residents in their electronic medical records (EMR's) on each of the three shifts daily and when they occurred. This affected seven (Resident #7, #8, #13, #24, #58, #70, and #71) of seven residents reviewed. Findings include: Review of Resident #7's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, epilepsy, hallucinations, delusional disorder, anxiety disorder, major depressive disorder, muscle wasting and atrophy, constipation, anemia, hyperlipidemia (high cholesterol) dysphagia (difficulty swallowing),and a history of a traumatic brain injury.Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had minimal difficulty hearing and clear speech. He was able to make himself understood and was able to understand others. His cognition was moderately impaired and mood indicators were present to include a poor appetite. His height was 75 inches, but no weight had been recorded, and any history of a significant weight loss (SWL) was unknown at the time. Review of Resident #7's care plans revealed he had an active care plan in place for being at risk for malnutrition that originated on 04/03/25. He had a history of an unplanned SWL due to refusals of meals when having UTI's. He had refused all facility supplements when attempted and was refusing to be weighed more frequently. The goals were for the resident to consume adequate energy to avoid significant, unplanned weight changes and for his intake to remain at least 50-75% of most meals. The interventions included the need to monitor and evaluate his meal percentage intake via meal intake records and observation.Review of Resident #7's meal intakes recorded for the past 30 days (03/10/26- 04/06/26) revealed not all three meals served each day were being recorded under the point of care history for amounts eaten in the electronic medical record (EMR) under the task tab. There were no meals recorded for any of the three meals served to the resident on 03/20/26, 03/22/26, 03/26/26, or on 03/27/26. Only one of three meals served to the resident were recorded on 03/25/26 and 04/05/26. Only two of the three meals served to the resident were recorded on 03/11/26, 03/13/26, 03/18/26, 03/19/26, 03/21/26, 03/29/26, and 04/03/26. Only 14 of those 30 days were all three meals recorded that had been served to the resident to reflect the amount of the meal that he had consumed. 2.Review of Resident #8's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included central cord syndrome at unspecified level of the cervical spine, post-laminectomy syndrome, cervical disc disorder w/ myelopathy, chronic obstructive pulmonary disease, anxiety disorder, Vitamin D deficiency, nutrition deficit, muscle weakness, pain, constipation, muscle spasms, depression, anemia, and hemiplegia and hemiparesis following CVA (stroke) affecting left non-dominant side. Review of Resident #8's significant change MDS assessment dated [DATE] revealed the resident had adequate hearing and clear speech. He was able to make himself understood and was able to understand others. His cognition was moderately impaired. He was dependent on staff for eating and toilet hygiene. He was always incontinent of his bladder and his bowel continence was not rated. His height was 66 inches and his weight was 119 pounds. No known SWL was noted and he was indicated to be on a therapeutic diet.Review of Resident #8's active care plans revealed the resident had a care plan in place for being at risk for malnutrition. He was known to have a SWL of 7.2 pounds/ 5.4% loss from his hospital weight likely due to fluid fluctuations. He was not accepting supplementation and the facility was trying a Magic Cup for the resident. The interventions included the need to monitor his intake and record every meal. He also had a care plan in place for bowel and bladder incontinence that was initiated on 08/04/25. The staff were to assist the resident with toileting as needed and to check the resident as requested for incontinence. Review of Resident #8's meal intakes for the past 30 days (03/08/26- 04/05/26) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recorded under the task tab of the EMR revealed not all meals served to the resident were being recorded in the medical record. No meal intakes were recorded for any of the three meals served on 03/12/26, 03/23/26, and 04/05/26. Only two of the three meals were recorded on 03/08/26, 03/11/26, 03/15/26, 03/18/26, and 03/29/26. Review of Resident #8's Urinary Control/ Frequency Point of Care History for the past 30 days (03/08/26- 04/05/26) revealed the staff were to mark if the resident was continent, incontinent, or did not void on each of the three shifts daily. There was documentation missing to indicate what his continence status was on a particular shift or a particular day during that 30 day period. There was no continence status recorded for the resident on any of the three shifts on 03/12/26, 03/18/26, 03/23/26, or 04/05/26. His continence status was only documented on one of the three shifts on 03/08/26, 03/09/26, 03/11/26, 03/13/26, 03/14/26, 03/15/26, 03/28/26, 03/29/26, and 03/31/26. His continence status was only documented on two of the three shifts on 03/10/26, 03/16/26, 03/17/26, 03/19/26, 03/20/26, 03/21/26, 03/22/26, 03/24/26, 03/25/26, 03/26/26, 03/27/26, 04/01/26, 04/02/26, 04/03/26, and 04/04/26. His continence status was only recorded for all three shifts once during that 30 day period occurring on 03/30/26. On 04/06/26 at 12:02 P.M., an interview with Regional Clinical Support #500 indicated it was expected that the nursing staff recorded the amount of a meal a resident consumed for all three meals served each day. They were also to indicate on each of the three shifts, if a resident was continent, incontinent, or did not void. He confirmed the computer software program they used broke it down into three separate shifts. Even though the nursing staff may work 12 hour shifts, they were to record that information on all three shifts (days, afternoons, and nights). 3.Review of Resident #13's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, adult-onset diabetes mellitus, muscle wasting and atrophy, abnormalities of gait and mobility, diarrhea, constipation, muscle weakness, major depressive disorder, anxiety disorder, pain, muscle spasms, and chronic kidney disease- stage 3.Review of Resident #13's quarterly MDS assessment dated [DATE] revealed the resident did not have any communication issues. Her cognition was moderately impaired and she was not known to display any behaviors or reject care. She was dependent on staff for toileting hygiene and was always incontinent of bowel and bladder. Review of Resident #13's active care plans revealed she had a care plan in place for being incontinent of her bladder related to a decreased awareness of need and dementia. The care plan was initiated on 07/03/25. The interventions included checking and changing her as requested for incontinence. Review of Resident #13's Urinary Control/ Frequency documentation under the Point of Care History found under the task tab for the past 30 days (03/08/26- 04/06/26) revealed the resident's continency status was not documented on each of the three shifts daily as it should have been. Her continence status was not documented for any of the three shifts on 03/0926, 03/14/26, 03/16/26, 03/21/26 or on 04/04/26. Her continency status was only documented on one of the three shifts on 03/08/26, 03/11, 03/12, 03/13, 03/15, 03/22, 03/23, 03/25, 03/28, 03/29, 04/03, and 04/05/26. Her continence status was only documented on two of the three shifts on 03/10/26, 03/17, 03/18, 03/19, 03/20, 03/24, 03/26, 03/27, 03/30, 03/31, 04/01, and 04/02/26. There were none of the days reviewed where her continence status was indicated to have been recorded for all three shifts during that 30 day time period. 4.Review of Resident #24's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included COPD, bipolar disorder with psychotic features, morbid obesity, heart failure, major depressive disorder, and hypertension. Review of Resident #24's quarterly MDS assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was not known to display any behaviors nor was she known to reject care. She was dependent on staff for toileting hygiene and was coded on the MDS as being frequently incontinent of bowel and bladder. Review of Resident #24's active care plans revealed she had a care plan in place for being incontinent related to impaired mobility. The interventions included the need to assist the resident with toileting and to provide incontinence care as needed. Review of Resident #24's Urinary Control/ Frequency documentation for the past 30 days (continued on next page)

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 04/06/2026

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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(03/08/26- 04/05/26 revealed the resident's continency status was not being recorded for each of the three shifts daily as it should have been. Her continence status was not documented for any of the three shifts occurring on 03/09/26, 03/24/26, and 03/31/26. Her continence status was only documented on one of the three shifts on 03/12/26, 03/13, 03/14, 03/15, 03/17, 03/18, 03/19, 03/23, 03/25, 03/28, 03/29, and 04/05/26. Her continence status was only documented on two of the three shifts on 03/08/26, 03/10, 03/11, 03/16, 03/20, 03/21, 03/26, 04/01, 04/02, 04/03, and 04/04/26. There was only three days during the past 30 days that the staff documented the resident's continence status on each of the three shifts and that was on 03/22/26, 03/27/26, and 03/30/26.5.Review of Resident #58's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a periprosthetic fracture around her internal prosthetic right hip joint, extrapyramidal movement disorder, muscle wasting and atrophy, muscle weakness, abnormalities of gait and mobility, colostomy status, history of falls, depression, insomnia, Post Traumatic Stress Disorder (PTSD), bipolar disorder, and hypertension.Review of Resident #58's admission MDS assessment dated [DATE] revealed the resident did not have any communication issues and she was cognitively intact. No behaviors or rejection of care was noted. She was dependent on staff for toilet hygiene and toilet transfers. She was coded on the MDS as being frequently incontinent of bladder. Review of Resident #58's active care plans revealed she had a care plan in place for being at risk for skin impairment. The interventions included the need to provide incontinence care as needed. Review of Resident #58's Urinary Control/ Frequency documentation under the task tab of the EMR for the past 30 days (03/08/26- 04/06/26) revealed the staff were not consistently documenting the resident's continence status on each of the three shifts daily. Her continence status was not documented for any of the three shifts on 03/11/26, 03/12, 03/18, 03/23, and 04/05/26. Her continence status was only documented on one of the three shifts occurring on 03/09/26, 03/13, 03/14, 03/15, 03/21, 03/28, 03/29, 03/31, and 04/03/26. Her continence status was only documented on two of the three shifts on 03/08/26, 03/10, 03/16, 03/19, 03/24, 03/25, 03/26, 03/27, 04/01, and 04/04/26. There were only five days out of the 30 reviewed where the resident's continency status was documented on all three shifts and those days were 03/17/26, 03/20, 03/22, 03/30, and 04/02/26. 6.Review of Resident #70's closed medical record revealed she was admitted to the facility on [DATE]. She was discharged on 03/05/26. Her diagnoses included acute on chronic diastolic heart failure, adult-onset diabetes mellitus, muscle wasting and atrophy, abnormalities of gait and mobility, morbid obesity, muscle weakness, COPD, overactive bladder, retention of urine, and constipation.Review of Resident #70's Medicare 5 Day MDS assessment dated [DATE] revealed her short and long term memory were intact. She was marked as having a modified independence for cognitive skills for daily decision making. She was not known to display any behaviors and she was not known to reject care. She was dependent on staff for toilet hygiene but toilet transfers were marked as not being applicable. She was always incontinent of bowel and bladder. Review of Resident #70's active care plans revealed she had a care plan in place for being at risk for skin impairment. The care plan included the intervention to provide the resident with incontinent care and to use barrier cream after each incontinence episode. Review of Resident #70's Urinary Control/ Frequency documentation under the task tab of the EMR from 02/20/26 thru 03/05/26 revealed the facility staff were not consistent documenting the resident's continence status on each of the three shifts daily as they should. Her continence status was not documented on any of the three shifts on 02/21/26 or 02/26/26. Her continence status was only documented on one of the three shifts occurring on 02/20/26, 02/22, 02/24, 02/27, 02/28, 03/01, and 03/02. Her continence status was only documented on two of the three shifts during that 14 day period on 02/23/26, 02/25, 03/03, 03/04, and 03/05/26. Her continence status was not documented on all three shifts on the same day for any of those 14 days reviewed. 7.Review of Resident #71's medical record revealed he was admitted to the facility on [DATE]. He remained in the facility until his discharge on [DATE]. His diagnoses included unspecified dementia, a history of a stroke, adult-onset diabetes mellitus, depression, unspecified (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protein-calorie malnutrition, muscle weakness, difficulty walking, gastroesophageal reflux disease, and constipation. Review of Resident #71's admission MDS assessment dated [DATE] revealed he had no communication issues and his cognition was moderately impaired. Set up/ clean up assistance with eating. His height was 68 inches and his weight was 175 pounds. He was not known to have had a SWL. Review of Resident #71's active care plans revealed he had a care plan in place for being at risk for malnutrition. The care plan was initiated on 12/30/25. The goals were for the resident to maintain his weight and to consume at least 50- 75% of most meals. The interventions included the need to monitor his intake and record every meal. Review of Resident #71's physician's orders revealed he was on a carbohydrate controlled diet with regular texture and thin liquids. He was to be up in his chair for all meals. Review of Resident #71's meal intakes recorded from 12/30/25 thru 01/17/26 revealed the facility staff were not consistently recording the percentages of meals the resident was consuming. None of the three meals served to the resident were recorded on 01/02/26, 01/09/26, 01/11/26, or 01/16/26. Only one of three meals served were recorded for 12/31/25, 01/03/26, 01/04/26, 01/12/26, and 01/17/26. Only two of three meals served were recorded on 01/01/26, 01/08/26, and 01/15/26. There were only seven days where all three meals had been recorded to reflect what percentage of the meal the resident consumed, while he was in the facility. On 04/06/26 at 4:30 P.M., an interview with the facility's Administrator and Regional Clinical Support # 500 confirmed meal intakes were not consistently being recorded to reflect the percentage of the meal each of the three residents consumed for all three meals served each day. No additional meal intakes were provided to show evidence the residents' plan of cares were being followed in regards to the recording of meal intakes for each meal served. They also confirmed the residents' continence status were not being documented on each of the three shifts daily as they should have been. Review of the facility's policy on Nutritional Documentation Guidance last reviewed in June 2025 revealed daily meal documentation was to be completed by the facility's direct care staff. Under the documentation guidelines, the nursing assistants or the licensed nurses were to observe meal intakes and document them in the facility's computer software program (PointClickCare) under the point of care.Review of the facility's policy on Compliance/ Ethics: Records and Documentation revised August 2025 revealed it was the facility's policy for accurate and complete record keeping and documentation, as it was critical to virtually every aspect of the facility's operations. It was the policy of the facility that all documentation should be timely, accurate, and consistent with applicable professional, legal, and facility guidelines and standards. That included all aspects of the facility's documentation, including resident assessments and care plans, and clinical records. The following deficiency was issued relative to incidental findings that were discovered during this complaint investigation completed on 04/06/26.

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	366244	A. Building B. Wing	04/06/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the facility failed to ensure infection control interventions were implemented related to maintenance of a nephrostomy collection bag. This affected one resident (Resident #7) of one residents reviewed for nephrostomy maintenance. The facility census was 69. Findings include: Record review revealed Resident #7 re-admitted on [DATE] with diagnoses including epilepsy, dementia, chronic kidney disease, pressure ulcer of left buttock, transient ischemic attack, anxiety, major depressive disorder, hypertension, and dysphagia. Review of Resident #7's physician orders revealed an order placed on 01/29/26 for enhanced barrier precautions every shift for prevention due to indwelling urinary catheter, nephrostomy tube, and wound (right nephrostomy insertion site with methicillin resistant staphylococcus aureus) (MRSA). Further review revealed the resident was ordered ceftriaxone (antibiotic) one (1) gram intramuscular (IM) every day for five days for a urinary tract infection (UTI) that was completed on 03/13/26.Review of Resident #7's quarterly Minimum Data Set (MDS) Assessment completed on 03/04/26 revealed a brief interview for mental status (BIMS) score of 08 indicating moderate cognitive impairment. Further review revealed the resident was dependent for toileting, showering, transfers, and mobility. The resident had an indwelling catheter (nephrostomy tube) and was frequently incontinent of bowel. Resident #7's care plan completed on 03/04/26 revealed the resident required enhanced barrier precautions related to a nephrotomy site to reduce the potential of spreading multi-drug resistant organisms. Observation on 03/18/26 at 8:20 A.M. revealed Resident #7's nephrostomy bag was laying on the floor, on the right side of the resident's bed. Interview and observation on 03/18/26 at 8:33 A.M. with certified nurse assistant (CNA) #33 confirmed the resident's nephrostomy bag was lying on the floor. The CNA stated previously there was a basin under the nephrostomy bag to prevent it from touching the floor but she was unsure what had happened to it, as she had been off for a few days. Review of facility policy titled infection control prevention program dated December of 2019 revealed it is the policy of the facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Residents have a right to reside in a safe environment that promotes health and reduces the risk of acquiring infections. The following deficiency was issued relative to incidental findings that were discovered during this complaint investigation completed on 04/06/26.