

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/10/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, facility investigation review, interviews and Hoyer lift user instructional guide review, the facility failed to ensure a safe transfer when mechanical lifts were not maintained in good repair. This affected one resident (#40) of three residents reviewed for mechanical lift use. The facility census was 62. Findings Include: Review of the medical record for Resident #40 revealed an admission date of [DATE] with the latest readmission date of [DATE]. Diagnoses included chronic respiratory failure with hypoxia, atrial fibrillation, diabetes mellitus, obesity, congestive heart failure, chronic obstructive pulmonary disease, anxiety disorder, osteoarthritis, dependence on supplemental oxygen, angina pectoris, depression, overactive bladder, constipation, pain, anemia, hyperlipidemia, gastro-esophageal reflux disease and hypertension. Review of the care plan dated [DATE] revealed the resident had an activity of daily living (ADL) self-performance deficit related to shortness of breath, limited mobility, cardiac diagnoses, dyspnea and obesity. Interventions included to assist with mobility as needed and Hoyer lift (a medical device designed to safely transfer individuals with limited mobility from one surface to another) for transfers. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the progress note dated [DATE] at 6:49 P.M. revealed during a transfer with the mechanical lift, an equipment malfunction occurred while the resident was being lifted resulting in being lowered onto the bed. The resident's arm made contact with the nearby wall during the incident. The resident was assessed immediately following event and was able to move affected extremity without pain, difficulty, or noted limitation. No acute distress was observed. Resident monitored for any changes in condition. Review of the medical record revealed no documentation of follow up from the incident. Review of the facility's investigation dated [DATE] with no time documented revealed the resident was being transferred to bed via Hoyer lift when the Hoyer tipped with resident over her bed. The resident put her left arm up to the wall and the Hoyer hit the light cover and broke it. The incident documented the resident was not injured. The facility removed the Hoyer from use and placed in the maintenance room. Review of the staff statement from Certified Nursing Assistants (CNA) #184 dated [DATE] revealed herself and CNA #123 was transferring the resident into bed with Hoyer number three and when the resident got over the bed it tipped and she hit the side of the wall. On [DATE] at 9:30 A.M., an interview with Licensed Practical Nurse (LPN) #108 revealed Hoyer number three was not steering correctly due to one of the wheels. The LPN revealed Resident #40 was being transferred using Hoyer number three and when she was over her bed the Hoyer lift tipped over and she hit the wall. She revealed the Hoyer also hit the light cover over her bed and broke it. On [DATE] at 10:53 A.M., an interview with CNA #122 revealed Hoyer number three was very hard to steer and she preferred not to use that lift. She revealed she had only had to use the lift, a couple of times, and it made her nervous. On [DATE] at 11:28 A.M., observation of Licensed Practical Nurse (LPN) #108 and CNA #113 transfer Resident #40 from her bed to power wheelchair revealed the resident's sling was under her. CNA #113 placed the Hoyer lift with the legs closed under the bed and hooked the sling to the Hoyer lift bar. CNA #113 lifted the resident up off the bed and moved the resident to her power (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/10/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair while LPN #108 steadied the resident in the sling. CNA #113 opened the legs and both staff members positioned the resident in her chair. Review of the maintenance log revealed an entry dated [DATE] for Hoyer number three indicating, Hoyer #3 needs fixed. It is a safety concern. The leg is broken and sways. On [DATE] at 9:54 A.M., an interview with the Regional Maintenance Director (RMD) #200 verified Hoyer lift number three was taken out of service and Maintenance Director (MD) #158 had worked on the lift and whatever he did, it was steering without difficulty. The RMD #200 revealed the lift was removed from service and was in his mechanical shop but he was unable to find anything wrong with the lift. Review of the Hoyer lift User Instruction Manual, dated 2014 revealed all Hoyer products are designed for minimum maintenance, however some safety checks and procedures are required. A schedule of daily tasks are detailed below. Make sure the lift moves freely on its castors and make sure the legs open and close correctly. This deficiency represents non-compliance investigated under Complaint Number 3034577.		

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 06/10/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure storage of resident toileting equipment was maintained in a manner to prevent the potential spread of infection. This affected one resident (#40) of six sampled residents. The facility census was 62. Findings Include: On 06/09/26 at 10:12 A.M., an observation of Resident #40's bathroom revealed a peach bariatric bedpan and a gray fracture bedpan laying on the floor under the resident's sink without a protective barrier. On 06/09/26 at 11:15 A.M., an observation of Resident #40's bathroom revealed the peach bariatric bedpan and the gray fracture bedpan laying on the floor under the resident's sink without a protective barrier. On 06/09/26 at 11:35 A.M., an interview with Licensed Practical Nurse (LPN) #108 verified the peach bariatric bedpan and the gray fracture bedpan was not store in a manor to prevent the potential spread of infection. On 06/09/26 at 2:30 P.M., an interview with Assistant Director of Nursing (ADON) #172 who functions as the facility's Infection Preventionist revealed the facility had no policy on how bedpans should be store but should be stored in a plastic bag off the floor. This deficiency represents non-compliance investigated under Complaint Number 3034577.		