

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

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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 08/21/2025
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 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. 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 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 366244	If continuation sheet Page 1 of 50

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#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 #80. MD #173 stated he had been focusing on the fire and did not get to it until 08/11/25 as he was the only maintenance man for the facility. On 08/19/25 at 10:08 A.M., interview with Housekeeping/Laundry Manager #113 revealed on the weekends there was only one housekeeper. The facility was down a person so all the rooms do not get cleaned. On 08/21/25 between 10:29 A.M. and 10:41 A.M., interview with the Director of Nursing (DON) verified the facility assessment staffing range of staff needed to provide adequate care and services for residents residing within the facility included licensed nurses providing direct care three to four on day shift and two to three night shift and the nurse aides (CNA) five to eight (CNA) for day shift and four to six CNA on the night shift for the facility. The DON stated they should never be under the minimum number of staff needed and it was her expectation on-call nursing management staff should come in to cover any part of the shift that was needed. The DON verified the above listed shifts with staffing concerns. On 08/21/25 between 8:32 A.M. and 8:50 A.M. interview with the DON stated the following: the facility currently does not have a nursing waiver. Staffing is based on resident care needs and census. Two of the five halls have higher acuity due to the residents require more assistance e.g. hooyer lifts, feeding, two person assists, etc. If the staffing numbers exceed the needs and census, nursing staff was sent home. The DON stated the minimum staffing for direct care nursing day shift was three nurses and night shift was two nurses for the full 12 hour shift (7a-7p/7p-7a). The minimum CNA's were five on day shift and four on night shift. The DON stated it should 'never' go below the above numbers and if it did, it would be her expectation that management staff or the on-call nursing manager would come in to cover that shift. On 08/21/25 at 1:47 P.M., interview with the Administrator revealed the facility continued to be hiring to fill vacant positions. The Administrator stated the facility did not have a Staffing Policy as they use their budget to determine staffing levels. This deficiency represents non-compliance investigated under Complaint Number 2569206.		

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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. 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 dishwasher 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 (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility surety bond, review of fund balance form, and interview the facility failed to ensure the surety bond had not lapsed. This affected 42 residents (Resident #11, #12, #13, #15, #16, #17, #19, #22, #23, #26, #27 (two accounts), #2 (two accounts), #28, #29, #31, #33, #34, #3, #39, #40, #5, #42, #43, #45, #47, #48, #49, #51, #52, #54, #8, #55, #10, #58, #59, #60, #61, #62, #65, #64, #9 (two accounts), and #67 out of 68 residents identified as having a resident funds account. Findings Include: Review of resident funds balance form dated [DATE] revealed there was 45 accounts for 42 residents (Resident #11, #12, #13, #15, #16, #17, #19, #22, #23, #26, #27, (two accounts), #2 (two accounts), #28, #29, #31, #33, #34, #3, #39, #40, #5, #42, #43, #45, #47, #48, #49, #51, #52, #54, #8, #55, #10, #58, #59, #60, #61, #62, #65, #64, #9 (two accounts), and #67 totaling \$28,884.44. Review of the surety bond dated [DATE] revealed the surety bond was effective from [DATE] and expired on [DATE]. There was no documented evidence the facility had renewed this surety bond or entered into a new surety bond. Interview on [DATE] at 11:00 A.M. with the Administrator confirmed the surety bond had expired on [DATE]. The Administrator reported corporate had reported the facility was changing companies, however there was no evidence the facility had a current surety bond. Interview on [DATE] at 4:27 P.M., with Corporate Staff Member #199 confirmed the facility did not change companies and decided to renew the surety bond with the previous company. The bill was paid today ([DATE] at 1:27 P.M.).		

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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. 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 (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. - 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, (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (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 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. 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 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. 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 an 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, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 impairment, was dependent for personal hygiene, did not walk or transfer, and needed substantial/maximum assistance to roll left and right. The resident was at risk for developing pressure ulcers, had pressure reducing devices, and ointments applied other than feet. The resident received insulin, antianxiety, antidepressant, anticoagulant and hypoglycemic medications. Observation on 08/11/25 at 11:07 A.M. revealed the resident was unshaven. He had long fingernails bilaterally that were heavily soiled with dark debris bilaterally. Interview on 08/11/25 at 11:08 A.M. with the resident revealed they do not offer to shave him. His sister shaved him last. Further, learned the staff does not trim or clean his fingernails. Observation and interview on 08/11/25 at 11:09 A.M. with LPN #179 verified Resident #19 was unkempt and unshaved. His fingernails were long bilaterally with dark debris under the nailbeds. 4. Review of Resident #5's medical record revealed a 07/14/25 readmission with diagnosis including metabolic encephalopathy, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, major depressive disorder, bipolar disorder, constipation, muscle weakness and atrophy, sepsis, vitamin D deficiency, pain, cyst of kidney, osteoarthritis of hip, irritable bowel syndrome with diarrhea, hypertension, retention of urine, dysphagia, anxiety, and hypercholesterolemia. A 12/06/21 plan of care had the resident at risk for declines/fluctuations in activity of daily living ability related to impaired mobility, metabolic encephalopathy, anxiety, bipolar disease, dyspnea, chronic obstructive pulmonary disease, weakness, chronic respiratory failure, and needs encouraged to get out of bed. Review of the 07/20/25 Minimum Data Set Assessment included the resident was moderately impaired for daily decision making. The resident needed some help with self care. The resident was set up for eating, and oral hygiene. Resident #5 received continuous oxygen therapy. Observation and interview on 08/11/25 at 12:05 P.M. with Resident #5 revealed her fingernails were long and dirty. The resident said she doesn't get her nails cleaned or cut. All fingers on her right hand had debris under the nailbeds. Her left hand had debris under her index finger and thumb. Interview on 08/11/25 at 2:54 P.M. with LPN #179 verified the resident's fingernails were long and soiled. This deficiency represents non-compliance investigated under Complaint Numbers 2588814, 2569206.		

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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 medical record review and interview the facility failed to ensure medical records were complete and accurate. This affected four residents (#48, #72, #77, and #80) of 27 resident records reviewed. Findings Include: 1. Closed record review revealed Resident #72 was admitted to the facility on [DATE] from another long-term facility. The resident admission diagnoses included malignant neoplasm of right and left female breast, atrial fibrillation, anemia, hyperlipidemia, hypocalcemia, anxiety, insomnia, essential hypertension, constipation, psoriasis, osteoporosis, chronic kidney disease, pain, use of anticoagulants, and difficulty walking. The resident expired in the facility on [DATE]. Review of Resident #72's altered cardiovascular status/related to hypertension, atrial fibrillation initiated [DATE] and revised [DATE] to monitor/document/report to physician as need any signs and symptoms of coronary artery disease: chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in capillary refill, color/warmth of extremities. Review of Resident #72's progress notes dated [DATE] at 2:50 P.M. revealed the resident was absent of vital signs at this time. A second nurse arrived to [NAME] at this time. The medical director was notified. The family at bedside. Further review of the resident medical record revealed no evidence change of condition or events that led up to the resident's death on [DATE]. Review of a typed statement authored by the Director of Nursing (DON) dated [DATE] revealed on [DATE] during morning meeting the staff were told nursing needed help with Resident #72. I, the Assistant Director of Nursing (ADON), the unit manager and Administrator all responded. Upon entering the room, the resident was noted to be hypoxic in recliner, oxygen was started as the resident was sats were high 60%. The crash cart was in room as the resident was a full code. Oxygen brought the resident sats to high 80's. When asked staff stated they were walking her to bathroom when she got weak and unsteady, so they sat her in the recliner and called for help. One nurse had already called 911 and the Administrator called the family to update the family. Family stated the resident was a do not resuscitate (DNR). The ADON went to the computer to pull a signed code status from the hospital records. The squad arrived and was updated on code status and left. Family arrived at same time and was taken to the resident's room. Family at bedside requested to keep resident comfortable but did not want morphine at this time. Stating it was okay with oxycodone to keep her comfortable. Physician aware, new orders obtained for oxycodone, code status updated approx. 11:25 A.M. Administrator stayed in room with family at that time. This DON checked in on resident and family and noticed resident with labored breathing, bilateral feet were starting to mottle. This DON spoke in depth to family about possibly starting morphine to keep resident comfortable and explained reasons why. Family agreeable to start morphine. Unit manager talked to physician for morphine orders around 2:00 P.M. At approximately 2:50 pm the resident was absent from vitals. Family was at beside. Interview on [DATE] at 8:11 A.M., with the DON confirmed there was no documentation evidence in the medical record of the resident change of condition leading up to the resident's death including (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vital signs, oxygen orders, and signed code status for DNR. The DON reported she had written a statement on [DATE] to provide to the surveyor explaining events and change of condition that led up to resident's death. Interview on [DATE] at 10:09 A.M., 11:37 A.M., 12:20 P.M., and 4:25 P.M., with Corporate Regional Nurse (CRN) #193 confirmed there was no documented evidence of change of condition leading up to the resident death in the medical record. The staff did not document vital signs or received signed orders for oxygen or DNR code status. The funeral home sent over the cause of death was arteriosclerotic cardiovascular diseases. 2. Review of Resident #48's medical record revealed a [DATE] admission with diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure, Obstructive sleep apnea (OSA), diabetes, asthma, hemiplegia, and anxiety disorder. Physician orders included a [DATE] order for Non-invasive home ventilator (Trilogy machine) Settings: AVAPS-AE Breath Rate: Auto Inspiratory time: N/A Sigh: off mouthpiece ventilation: NO PS min-5 comment-20 PS max-20 comment-25 EPAP min-5 EPAP max:15 AVAPS rate: 5 max pressure: 35 VT Target: 500 heated humidifier with mask, a [DATE] order for routine cleaning of trilogy supplies day shift every Sunday, [DATE] order to wipe Trilogy mask in the mornings after removal and change oxygen supplies every night shift on Sunday. Interview on [DATE] at 11:45 A.M. with Resident #48 revealed she has a bipap machine and mask but they are not putting it on her as it is broken. On [DATE] at 2:49 P.M. interview with Licensed Practical Nurse (LPN) #179 revealed part of the gel came off of the Trilogy mask and they could not get a good seal. Another mask was ordered. Observation at the time of the interview revealed there was an unopened box on the top of the resident's cabinet. LPN #179 looked at the box but did not open it. The outside of the box did not identify what was inside the box. Observation at the time of the interview verified the bipap machine on the bedside table had a mask that was not contained in a bag for sanitation. Interview on [DATE] at 6:01 P.M. with the resident included she wore the Trilogy two nights ago. Last night it beeped and so she did not wear it. She did not wear it for about a month because of the mask not fitting. The Trilogy mask was lying on the bedside table not contained in a bag. Interview on [DATE] at 7:00 P.M. with LPN #108 revealed she ordered the new mask on [DATE] and it was delivered on [DATE]. Interview on [DATE] at 7:02 P.M. with LPN #179 verified the mask was in the unopened box on top of the resident's cabinet she looked at on [DATE]. The box did not identify what was in the box. Review of the Treatment Record revealed the device was marked as applied at night on [DATE], [DATE], [DATE], and [DATE] when the seal on the old mask was broken. This documentation is inaccurate as a new mask was ordered [DATE], was received [DATE] but not opened until [DATE]. Interview on [DATE] at 12:03 P.M. with LPN #179 verified the resident had the Trilogy machine signed off as being applied to the resident when the mask was broken and it would have just beeped (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because of the bad seal. LPN #179 verified the mask was not applied as indicated on the treatment sheet [DATE], [DATE], [DATE] or 08/10 /25 after the new mask arrived and was not opened for use until [DATE]. 3. Medical record review revealed Resident #80 was admitted on [DATE] with diagnoses including end stage renal disease, dependence on dialysis. Review of the dialysis Progress Note dated [DATE] revealed Resident #80 was ordered two new medications including calcium acetate (phosphate binder) 667 milligrams (mg) with the first bite of each meal. The physician order was not transcribed until [DATE]. Review of the electronic Medication Administration Record revealed calcium acetate 667 milligrams (mg) was ordered on [DATE] to be administered with the first bite of the meal. The medication was documented as being unavailable for administration except for three doses on [DATE] and two doses on [DATE]. Review of the record revealed no evidence calcium acetate 667 (mg) was available to be administered while Resident #80 was a resident at the facility. On [DATE] at 12:15 P.M., interview with the Director of Nursing verified the facility did not receive any calcium acetate 667 (mg) as ordered from either the pharmacy or the dialysis center; therefore, Resident #80 did not receive the medication between [DATE] and [DATE]. The DON verified the electronic Medication Administration Record indicated Resident #80 had received three doses of calcium acetate on [DATE] and two doses of calcium acetate on [DATE]; however, the DON verified this was not accurate due to the calcium acetate was never received at the facility. 4. Medical record review revealed Resident #77 was readmitted on [DATE] with diagnoses including diabetes mellitus. Review of the electronic Physician Orders dated [DATE] revealed to administer lispro insulin per sliding scale intramuscularly (IM) before meals for diabetes. Review of the electronic Medication Administration Record dated [DATE] revealed Resident #77 was administered five doses of lispro insulin IM between [DATE] and [DATE]. Review of the National Institutes of Health: lispro insulin revised [DATE] revealed the insulin was to be administered subcutaneously. On [DATE] at 2:23 P.M., interview with Registered Nurse #193 verified Resident #77's lispro insulin order was inaccurate for the route of administration.		

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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. 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. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 at 7:22 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. 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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 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 it 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 (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 positioned the metal serving pan to the back of the shelf stating the pan should catch the leaking water now. Review of the TELLs maintenance request revealed no request to fix a leaking refrigerator in the kitchen. Interview on 08/21/25 at 11:22 A.M. with Maintenance Staff #173 revealed a lot of the work he does not get on a TELLs request. He is told in the halls things that need completed. He included he had known the refrigerator was leaking for a couple weeks. He needs to clean/fix the condensation drain and has not gotten to it yet. When asked, he confirmed he was the only maintenance man for the facility. He does have a regional maintenance staff that will assist. This deficiency represents non-compliance investigated under Complaint Numbers 2588814, 2584767, 2583878, and 2569206.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, it was determined the facility failed to ensure residents' code status' were accurate. This affected two residents (#2, #72) of 28 residents reviewed for accurate code status. Findings Include: 1. Closed record review revealed Resident #72 was admitted to the facility on [DATE] from another long-term care facility. The resident admission diagnoses included malignant neoplasm of right and left female breast, atrial fibrillation, anemia, hyperlipidemia, hypocalcemia, anxiety, insomnia, essential hypertension, constipation, psoriasis, osteoporosis, chronic kidney disease, pain, use of anticoagulants, and difficulty walking. The resident expired in the facility on [DATE]. Review of Resident #72's transfer records from the other long-term facility dated [DATE] revealed the resident was admitted to the facility on [DATE] from the hospital after sustaining a fall with a fracture. Further review of the resident face sheet revealed there were no advanced directives selected for the residents. Review of Resident #72's admission assessment dated [DATE] revealed no documented evidence of the resident's code status. Review of Resident #72's code status plan of care initiated [DATE] and revised [DATE] revealed to discuss/review the resident's code status with resident/family quarterly and as needed. Support the residents/family with their decision and honor preference. The resident code status was full code. Review of Resident #72's signed orders revealed the resident was a full code from [DATE] to [DATE]. Review of Resident #72's history and physical note created on [DATE] revealed the physician had seen the resident on [DATE]. The resident's code status was DNR Comfort Care Arrest (DNRCC-A). There was no documented evidence the physician had completed a State of Ohio DNR Order form or a new order for DNRCC-A. Review of Resident #72's late entry care conference note created [DATE] (after the resident death) and dated [DATE] and authored by the Director of Nursing (DON) revealed the resident's code status was DNRCC-A. Review of the facility policy titled Advance Directive Guidance (dated 04/2018 and revised 05/2024) revealed the full code the resident may choose to have full resuscitative measure used in the event their heart stops or breathing stops. DNR-CC informs health care providers that the resident doesn't wish any heroic measures attempted. DNRCCA means aggressive treatment of medical conditions but will stop all aggressive treatment at the point when the resident heart or breathing stops. The facility's procedure revealed upon admission, a nurse would question the resident about advance directives. The nurse may need to educate the residents on their choices for advance directives. The resident may want to decide immediately. All residents without advance directives would be treated as a full code. If the resident wants to decide their advance directives after speaking to the nurse, physician, or advanced nurse practitioner, the nurse or social service would initiate an Ohio Advanced (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Directives for with the resident signature. If the resident was unable to sign, the appointed resident may sign. The Ohio Advanced Directive form will need to be fully executed by the resident physician or physician extender; next a nurse would obtain a physician order follow the advanced directive wishes of the resident. The advanced directive order would be entered into the resident electronic medical record. The advanced directive physicians order in the electronic health record would be the primary source the nurse would follow during a code blue situation. This can be found immediately when accessing the resident electronic record. When the electronic health record is offline/unavailable for whatever reason, the fully executed Ohio Advance Directive form located in front of the resident's hard chart will serve as the secondary source for the nurse to follow during a code blue situation. The Director of Nursing (DON) or designee would be responsible for reporting on auditing and managing each Ohio Advanced Directive fully executed form with each resident's advanced directive physician order. Interview on [DATE] at 8:11 A.M. with the director of nursing (DON) confirmed the resident was admitted to the facility on [DATE] and the provider had signed an order for full code on [DATE]. The physician had completed a history and physical progress note on [DATE] and indicated the resident's code status was a DNRCC-A, however he never wrote a new order or completed a State of Ohio DNR order form. On [DATE] the resident started to decline, and the family was at the resident beside and reported they did want the resident sent out and she had a DNRCC code status on file at the hospital. The facility had access to the hospital records and found an old DNRCC-A code status form. Interview on [DATE] at 11:37 A.M., with Corporate Regional Nurse (CRN) #193 confirmed Resident #72 signed orders and care plan indicated the resident was a full code. The physician had documented on the history and physical on [DATE] the resident was a DRNCC-A, however neither the order nor the care plan was changed or clarified. The CRN #193 confirmed the resident started to decline and the family did not want the resident sent out on [DATE] and the family had reported the resident had a DNRCC-A on file at the hospital. The facility received a verbal order for DNRCC-A a few hours before the resident expired, however the order was never signed by a provider. 2. Review of Resident #2's record revealed a [DATE] 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 [DATE] Quarterly Minimum Data Set (MDS) Assessment revealed the resident was severely impaired for daily decision making. Review of the electronic medical record dated [DATE] at 4:59 P.M. revealed the resident was a full code ordered [DATE]. Review of the paper record/chart revealed an Advanced Directive for a Do Not Resuscitate Comfort Care (DNRCC) (only comfort care is provided, with no resuscitative measures like CPR, to be undertaken at any time. This order is activated immediately upon being signed by a healthcare provider and is effective in all care settings, including at home or in a hospital) signed [DATE] was filed in the medical record. Interview on [DATE] at 5:05 P.M. with Licensed Practical Nurse (LPN) #148 and LPN #159 verified the order in the electronic medical record of a Full Code did not match the signed advanced directive (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for a DNRCC. Interview on [DATE] at 5:11 P.M. with Licensed Practical Nurse (LPN) #159 revealed she called the resident's daughter. Resident #2's daughter said the resident was to be a DNRCC. The hospital did not have her advanced directive so it was not sent with the hospital discharge. The facility made her a full code because they did not have advance directive paperwork. Review of the admission Packet (not dated) included all directives will be included in the resident medical record for reference by the attending, consulting physician, and nursing staff. Review of the facility's Advanced Directive Guidance (approved 05/2025) included the nurse will obtain a physician order following the advanced directive wishes of the resident. The advanced directive order will be entered into the resident's electronic health record. The advanced directive physician order in the electronic record will be will the primary source the nurse will follow during a code blue situation. This can be found immediately when assessing the resident's electronic record. When the electronic health record is offline/unavailable for whatever reason, the fully executed Ohio Advanced Directive form located in the front of the resident's hard chart will serve as the secondary source for nurses to follow during a code blue situation.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review and interview, the facility failed to ensure pharmacy recommendations were addressed including a rationale for declining gradual dose reductions. This affected one resident (#67) of five residents reviewed for unnecessary medications. The census was 68. Findings Include: Medical record review revealed Resident #67 was admitted on [DATE] and readmitted on [DATE] with diagnoses including depression, anxiety disorder and traumatic subdural hemorrhage. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #67 was cognitively intact for daily decision-making and had an anxiety disorder. Review of the Pharmacist's Recommendation to Prescriber dated 12/09/24 revealed Resident #67 had a PRN (as needed) order for the psychotropic medication, Lorazepam (anxiolytic) 0.5 milligrams. The pharmacist stated per CMS, PRN psychotropic medications are limited to 14 days. If use is beyond 14 days, the rationale and estimated duration of use must be documented. The pharmacist provided the physician with the following choices to comply with the CMS regulations: Discontinue the PRN or add a stop date. Further review of the Pharmacy recommendation revealed the nurse practitioner declined the above recommendation, did not date her response and failed to document a rationale as required. On 08/13/25 at 4:50 P.M., interview with Registered Nurse #193 verified no prescriber rationale was provided as required. On 08/13/25 at 5:29 P.M., interview with the Director of Nursing verified there was no rationale documented as to why the recommendation was declined by the nurse practitioner and this should be written. Review of the policy Psychoactive/Antipsychotic Drugs revised January 2021 revealed all residents receiving psychoactive drugs will be evaluated for necessity of the drug per OBRA '90 psychoactive drug monitoring schedule. The intent of the policy was to encourage safe and effective psychoactive drug therapy through the cooperative efforts of the physician, pharmacist, nursing staff and mental health professionals to establish specific goals and objectives for review of the use of psychoactive medications. Clinical contraindications will be documented by the physician in the medical record.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to complete an admission comprehensive assessment timely as required. This affected one resident (#80) of 24 residents sampled. The census was 68. Findings Include: Medical record review revealed Resident #80 was admitted on [DATE] with diagnoses including fractured vertebrae, end stage renal disease, dependence on renal dialysis and dysphagia. The resident was discharged from the facility on 08/18/25. Review of Resident #80's Minimum Data Set 3.0 (MDS) assessments in the electronic medical record revealed no completed MDS assessments were available for review. Both the admission MDS assessment dated [DATE] and a 5-day MDS assessment dated [DATE] were not completed or submitted as required within 14 days of admission. On 08/19/25 at 3:20 P.M., interview with Registered Nurse (RN) #123 verified Resident #80 did not have a MDS assessment for review due to the assessments had not been finished or submitted to CMS to date. RN #123 stated she has been busy and just needed to get them entered and submitted. On 08/21/25 at 2:27 P.M., review of the electronic medical record revealed Resident #80's MDS 5-day assessment was 'Completed' but not submitted to CMS and the admission assessment was 'Export Ready'. The resident's Discharge Return Not Anticipated assessment dated [DATE] was listed as being 'In Progress'.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview the facility failed to ensure a significant change of condition Minimum Data Set (MDS) was completed timely. This affected one resident (#3) of one record reviewed for hospice. Findings Include: Medical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus, peripheral vascular disease, heart failure, urinary retention, depression, and was admitted to hospice on 07/07/25. Review of Resident #3's orders dated 07/07/25 revealed the resident was admitted to hospice. Review of Resident #3's hospice plan of care dated 07/10/25 revealed the resident/responsible party had elected to utilize hospice/end-of-life care services. Review of Resident #3's MDS revealed no evidence of significant change of condition MDS was completed. Interview on 08/19/25 at 3:22 P.M., with Registered Nurse/MDS Nurse #123 confirmed Resident #3 should have had a significant change of MDS completed on 07/07/25 when the resident had a decline and was ordered hospice services. The RN reported she was not aware until 08/11/25 (date the survey started) the resident was ordered hospice. The RN reported she started a significant change MDS on 08/11/25 and it was still pending.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure comprehensive assessments were accurate. This affected one resident (#54) of 24 residents reviewed for comprehensive assessments. The census was 68. Findings include: Medical record review revealed Resident #54 was admitted on [DATE] with diagnoses including diabetes mellitus. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #54 received one dose of insulin. Review of the electronic Physician Orders dated May 2025 revealed Resident #54 did not have an order for insulin. Review of the electronic Medication Administration Record dated May 2025 revealed Resident #54 did not receive insulin during the quarterly MDS assessment reference dates. On 08/18/25 at 12:28 P.M. interview with Registered Nurse #123 verified Resident #54 did not receive insulin and the MDS assessment was not accurate.		

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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. **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. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to obtain treatment orders and comprehensively assess skin alterations. This affected two residents (#19, #77) of three residents reviewed for care and treatment. Findings Include: 1. 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, major depressive disorder and pyoderma gangrenosum, a rare inflammatory skin disease where painful pustules or nodules become ulcers that progressively grow. 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 (MDS) Assessment revealed the resident was independent for daily decision making, had bilateral lower extremity functional impairment, was dependent for personal hygiene, did not walk or transfer, and needed substantial/maximum assistance to roll left and right. The resident was at risk for developing pressure ulcers, had pressure reducing devices, and ointments applied other than feet. The resident received insulin, antianxiety, antidepressant, anticoagulant and hypoglycemic medications. Review of the progress notes dated 08/09/25 at 8:08 P.M. revealed while removing moon boots to do dressing change to right foot resident noted to have new skin impairment to bilateral calves. Both areas measured approximately 8.5 x 8.5 centimeters. Left calf area noted with yellow/green drainage and right calf serosanguinous. New orders received to obtain Complete Blood Count, Basic Metabolic Panel, Erythrocyte Sedimentation Rate, C-Reactive Protein and wound culture from left area. Areas to bilateral calves cleansed with wound cleanser, applied xeroform, covered with ABD, wrapped with kerlix, secured with tape, and pressure offloaded from areas. Interview on 08/11/25 at 11:08 A.M. with the resident revealed his left leg popped open on Saturday and green drainage came out. His sister wants him to go to the hospital for intravenous antibiotics. He had it cultured on Saturday and was started on oral antibiotics. Observation on 08/11/25 at 11:08 A.M. revealed he had a kerlix dressing on his left calf dated 08/09/25. Observation and interview on 08/11/25 at 11:09 A.M. with licensed practical nurse (LPN) #179 verified Resident #19's calf dressing was dated 08/09/25. Review of the physician orders revealed no orders for a dressing to the resident's left or right calf. Review of the resident's treatment sheet revealed no physician orders for the dressings on his right and left calf. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/12/25 at 3:09 P.M. with Registered Nurse (RN) #193 verified there were no orders written for the dressing on the residents' right and left calf. RN #193 verified the nurse did not write orders for dressings for the newly identified areas on the right and left calves. Review of the Wound Management Program (updated 02/2024) included any resident with a wound receives treatment and services consistent with the residents goals of treatment. A commitment to the Wound Management Program is demonstrated by implementation of processes founded on acceptable standards of practice, research driven clinical guidelines, and interdisciplinary involvement. 2. Medical record review revealed Resident #77 was admitted on [DATE] with diagnoses including peripheral vascular disease, diabetes mellitus and lower extremity amputations. Resident #77 was readmitted to the hospital on [DATE] with a diagnosis of altered mental status. Review of the admission Packet -V 4 dated 08/08/25 revealed Resident #77 had an open, red area to the coccyx and bilateral lower legs were amputated. Review of the Illustration of Documentation and Measurements of Skin Areas dated 08/08/25 revealed an open area measuring 0.5 centimeters (cm) in length (l) by 0.5 (cm) in width (w) to the coccyx, an area measuring 15.0 (cm) in (l) by 1.0 (cm) in (w) to the right lower leg, and two open areas to the left lower leg measuring 0.5 (cm) in (l) by 1.0 (cm) in (w) to the medial aspect of the knee and an area to the lower leg measuring 11.5 (cm) by 1.0 (cm). There was no evidence of a comprehensive assessment of the skin areas including but not limited to the type of wound, description, odor and/or drainage. Review of the Skin Check Weekly dated 08/08/25 revealed erythema/redness appearance of skin. The resident also had wounds on lower extremities due to amputations and an open wound on coccyx, groin erythema. There was no evidence of what type of wounds the skin impairments were. Review of the Order Summary Report dated 08/08/25 revealed to cleanse coccyx with normal saline, pat dry, apply triad and leave open to air. Apply neomycin bacitracin ointment to right below the knee amputation daily for wound healing. Review of the record on 08/11/25 revealed no evidence of a comprehensive assessment of Resident #77's wounds. Review of the policy: Wound Management (revised February 2024) revealed any resident with a wound was to receive treatment and services consistent with the resident's goals of treatment. The goal is one of promoting healing and minimizing infection unless a resident's preferences and medical condition necessitate palliative care as the primary focus. A commitment to the wound management program was demonstrated by implementation of processes founded on accepted standards of practice, research-driven clinical guidelines, and interdisciplinary involvement. At the time of admission, the discharge records from the prior facility are reviewed for information relating to wounds or a n alteration in skin integrity. Wounds are assessed at the time of admission (same shift) and if not possible, within 24-hours. The admission skin assessment includes at a minimum: interview of resident or family about history of skin alterations. Physical evaluation to include identification of skin integrity and tissue intolerance, skin alterations present on admission, skin discolorations and any evidence of scarring on pressure points. Signs/symptoms diagnosis of PVD, bed mobility, continence, recent surgical procedure, head to toe skin assessment nutritional status and issues, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completion of a Skin Risk assessment tool. Risk reduction measures are initiated if determined appropriate, notification of any skin impairment identified on admission, orders verified or obtained PRN, an admission/interim care plan is developed. Assessments and interventions implemented are documented in the resident record. Comprehensive wound assessment includes the following parameters at a minimum including location and staging of wound; length, width and depth measurements recorded in centimeters; direction and length of tunneling and undermining; appearance of the wound base; type and % of tissue in wound; drainage amount and characteristics including color, consistency and odor, wound edges. Type of wounds (pressure-related as opposed to non-pressure related are differentiated. On 08/13/25 at 8:35 A.M., interview with the Director of Nursing verified there was no comprehensive skin assessment done on admission for Resident #77's wounds. The DON stated admission on Friday and the weekend were not completed until the wound nurse/designee returns the following week. The DON verified she would not be able to know if the current treatment was appropriate or not, or if the area had declined due to there was no comprehensive assessment completed upon admission. On 08/14/25 at 1:23 P.M., interview with the Assistant Director of Nursing verified there was no comprehensive assessment of Resident #77's wounds upon his admission dated 08/08/25.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, policy review, and interview the facility failed to complete comprehensive assessment of pressure ulcer skin impairments, failed to provide pressure prevention interventions, and failed to follow infection control practices during the changing of a pressure ulcer dressing. This affected one resident (#77) of three residents reviewed for pressure ulcers. The facility census was 68. Findings Include: 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 Illustration of Documentation and Measurements of Skin Areas dated 08/08/25 revealed an open area measuring 0.5 centimeters (cm) in length (l) by 0.5 (cm) in width (w) to the coccyx. There was no evidence of a comprehensive assessment of the skin areas including but not limited to the type of wound, description, odor and/or drainage. On 08/12/25 at 3:15 P.M., interview with Registered Nurse (RN) #193 verified there was no comprehensive assessment completed on 08/08/25 of the resident's skin and then he was discharged to the hospital on [DATE] and returned to the facility on [DATE]. Review of the Skin assessment dated [DATE] revealed an open area to the coccyx was classified as moisture associated skin damage that measured 4.5 centimeters (cm) in length (l) by 3.0 (cm) in width (w) and no depth. Review of the Wound Care re-consultation visit for wound care services dated 08/14/25 revealed multiple wounds including a Stage 3 pressure (defined as full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) 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 and this was the first evaluation of this full thickness wound. Treatment orders revealed cleanse with normal saline and apply triad past and leave open to air every shift and PRN. 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. Review of the care plan At Risk for Impaired Skin Integrity/Pressure Ulcers (initiated 08/08/25 and revised on 08/15/25) revealed current wounds requiring dressing changes, chronic/acute skin condition increasing risk of open area and bilateral below the knee amputation. Interventions included no briefs on when in bed, peri-care after each incontinence episode, pressure reduction devices if ordered and treatments as ordered. On 08/18/25 at 2:53 P.M., observation of Resident #77 revealed he was sitting in wheelchair with no pressure relieving cushion. The resident's dressings to bilateral BKA were loose and falling off. The left BKA wound was gaping and observed to have black/brown necrotic tissue covering 75 % of the wound. At the time of the observation Resident #77 stated he had gotten a shower and they needed changed. The resident stated his butt is sore and has to keep shifting his weight back and forth. The resident was observed not to have a cushion in his wheelchair. On 08/18/25 at 3:02 P.M., observation with Licensed Practical Nurse (LPN) #108 verified the above observation and stated she would let his nurse know. On 08/19/25 at 12:37 P.M., Resident #77 was observed laying in bed eating his lunch. The resident was observed wearing an incontinence brief. On 08/19/25 at 2:35 P.M., Resident #77 was observed laying in bed on his back. The resident was covered with a sheet. On 08/19/25 between 4:15 P.M. and 5:01 P.M., observation of the coccyx pressure ulcer treatment and incontinence care revealed licensed practical nurse (LPN) #131 and certified nursing aide (CNA) #107 were observed washing their hands, applied gloves. CNA #107 gathered incontinence supplies, positioned the resident in bed The resident was wearing an incontinence brief in bed and had been incontinent of urine. LPN #131 and CNA #107 rolled the (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, wiped across the rectum and over the Stage 3 pressure ulcer. CNA #107 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 onto his right side. LPN #131, using the same gloved hands, used her thumb to press on various areas of the peri-wound and in the wound bed prior to applying triad cream around the wound perimeter but not in the wound bed itself. The resident was repositioned on his back, an incontinence brief was applied and the head of the bed was 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. 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. Review of the General Note dated 08/20/25 at 7:04 A.M. with an effective date of 08/19/25 revealed coccyx appears moist with small amount of clear drainage noted. Border was pinkish in color clearly defined small amount of slough noted in wound bed. Physician contacted and physician gave order for calcium alginate cut to size covered with dry, clean dressing to be changed daily and as needed. Review of the Wound Management Program (revised February 2024) revealed wound management program to promote the residents highest level of functioning and well being and to minimize the development of facility acquired pressure injuries unless the individuals clinical condition demonstrates unavoidable. Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. The goal is one of promoting healing and minimizing infection unless a residents preferences and medical condition necessitate palliative care as the primary focus. admission Skin and wound assessment and management included: at the time of admission, the discharge records from prior facility revealed for information relating to wounds. Wounds are to be assessed at the time of admission (same shift) and if not possible, within 24 hours.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital records, and interview the facility failed to ensure a resident gastrostomy tube was properly managed. This affected one resident (#32) of one resident reviewed for gastrostomy tube. The facility census was 68. Findings Include: Medical record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including unspecified protein-calorie deficit, gastrostomy, gastro-esophageal reflux disease, bariatric surgery status, peritoneal abscess, pain, vitamin deficiency, nausea with vomiting, hypokalemia, insomnia, muscle spasms, vitamin D deficiency, sepsis, chronic obstructive pulmonary disease, drug induced subacute dyskinesia, type diabetes, muscle wasting, muscle weakness, depression, attention-deficit hyperactivity, venous insufficiency, and atherosclerotic heart disease. Review of Resident #32's hospital discharge orders dated 07/23/25 revealed to repeat the computed tomography (CT) scan next week. The office will call with appointment. Call the office if you have any questions or concerns. Follow up with the surgical specialist on July 28th at 1:30 P.M. Review of Resident #32's medical record revealed no evidence a CT scan was completed the following week nor evidence the resident had seen the specialist on 07/28/25. Review of a dietary note dated 07/24/25 revealed the resident was on a full liquid diet until follow-up with surgeon. Review of Resident #32's orders dated 07/25/25 revealed to flush enteral tube with 30 milliliters (ml) of water daily to maintain patency. Review of Resident #32's progress note dated 08/05/25 revealed the resident returned back from surgical specialist. The resident continues to have gastrostomy tube in place-not to be used. New diet order-soft diet until follow up appointment in one week. There was no evidence that the resident was ordered a repeat CT scan. Review of Resident #32's feeding tube plan of care dated 07/23/25 revealed flush enteral tube per order to maintain patency. Provide treatment to enteral tube site per order. Review of Resident #32's plan of care dated 07/25/25 for potential for alternation in gastro-intestinal status related to enteral tube in place, gastric reflux disease, liquid diet, history of gastric bypass surgery, and hyperlipidemia revealed to give medication as ordered. Monitor/document side effects and effectiveness. Maintain full liquid diet per physician orders, obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated. Review of Resident #32's surgical specialist note faxed 08/19/25 and dated 08/05/25 revealed the resident had a laparoscopic drainage of intraperitoneal abscesses and gastrostomy tube placement. The assessment plan revealed the resident was doing remarkably well after surgery. She was tolerating blended diet along with full liquids. Will advance to soft diet. She denies fever. Will obtain CT scan of the abdomen/pelvis to assess for any remaining fluid collection. If CT is reassuring, will remove gastrostomy tube next week. Return in one week around 08/12/25. Review of Resident #32's medical record revealed no evidence of an order or appointment for CT scan. Interview on 08/11/25 at 10:44 A.M., with Resident #32 revealed she was supposed to have a CT scan today before her appointment with the surgical specialist, however the facility didn't schedule the CT. Driver/Scheduler #177 told her that it was her responsibility to schedule the CT not the facility's. The resident reported that her family thought it was the facility's responsibility since she was a resident at the facility. The resident reported she was upset because she was hoping to go home tomorrow. Interview on 08/13/25 at 12:01 P.M., with Driver/Scheduler #177 confirmed she had gone to the appointment on 08/05/25 with Resident #32 and the specialist had told her that the resident needed an CT scan done before her next appointment on 08/11/25. The Driver/Scheduler reported she tried to schedule the CT scan; however, she was not authorized, and the hospital was attempting to call the resident, however she would not answer her phone. The Driver/Scheduler reported she was also waiting for authorization from the insurance which can take up to 14 days. The schedule confirmed the resident appointment with the specialist had to be cancelled on 08/11/25 due to the CT scan was not performed. The (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Driver/Scheduler confirmed there was not an order in the resident medical record for the CT scan, and she did not attempt to help the resident schedule the appointment for the CT scan. Interview on 08/18/25 at 3:00 P.M. with Resident #32 revealed she doesn't recall the hospital attempting to call her regarding scheduling a CT scan. The resident reported her mom was responsible for scheduling her appointments prior to admission to the facility. The resident reported that her mother and herself felt the facility had dropped the ball and it should have been the facility's responsibility to arrange the appointment and authorization for the CT scan. The resident reported now she will have to remain at the facility for another few weeks when she was supposed to be discharged home on [DATE]. Interview on 08/19/25 at 8:41 A.M., with the Administrator and Corporate Regional Nurse (CRN) #193 confirmed the resident hospital discharge orders indicated the resident was to have a CT in one week which was not followed upon admission. The CRN #193 confirmed the resident had seen the specialist on 08/05/25 and the CT scan was re-ordered, however there was no documentation in the medical record regarding the CT scan, and it was never ordered. CRN #193 reported the facility called the specialist office and they were going to order a STAT CT scan today, which it should have been ordered STAT on 08/05/25. The facility had requested notes from the specialist office visit on 08/05/25 per the surveyor's request, however they had not received them at this time. CRN #193 reported the facility was working on getting the CT done this Thursday and moving up the resident appointment with the specialist.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure respiratory equipment was maintained in a sanitary manner and failed to assist with the application of a respiratory device. This affected three residents (#5, #45 and #48) of three residents reviewed for respiratory care. The census was 68. Findings Include: 1. Review of Resident #48 revealed a 05/18/22 admission with diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure, Obstructive sleep apnea (OSA), diabetes, asthma, hemiplegia, and anxiety disorder. Review of the 06/30/25 Quarterly Minimum Data Set Assessment included the resident was moderately impaired for daily decision, on oxygen and a non invasive mechanical ventilator. Physician orders included an order dated 03/25/22 for non-invasive home ventilator (Trilogy machine) Settings: AVAPS-AE Breath Rate: Auto Inspiratory time: N/A Sigh: off mouthpiece ventilation: NO PS min-5 comment-20 PS max-20 comment-25 EPAP min-5 EPAP max:15 AVAPS rate: 5 max pressure: 35 VT Target: 500 heated humidifier with mask, a 03/23/25 order for routine cleaning of trilogy supplies day shift every Sunday, 03/18/25 order to wipe Trilogy mask in the mornings after removal and change oxygen supplies every night shift on Sunday. The resident had a care plan revised on 08/11/25 related to an alteration in oxygen exchange / perfusion COPD, asthma, obstructive sleep apnea (OSA), and respiratory failure with hypoxia/hypercapnia. Has oxygen (O2) and bi-pap, self removes O2, and will refuse Bipap. Interventions included to provide respiratory treatment and oxygen as per physician orders. Interview on 08/11/25 at 11:45 A.M. with Resident #48 revealed she has a bipap but they are not putting it on her, it is broken. Observation at the time of the interview revealed a bipap machine on the bedside table. The mask was on the bedside table and was not contained in a bag for sanitation. The resident had oxygen on per nasal cannula at 4 1/2 Liters per Minute (LPM). She had a humidification bottle dated 06/15/25 on the oxygen condenser unopened and not attached to the oxygen cannula. On 08/11/25 at 2:49 P.M. interview with Licensed Practical Nurse (LPN) #179 revealed part of the gel came off of the Trilogy mask and they could not get a good seal. Another mask was ordered. Observation at the time of the interview revealed there was an unopened box on the top of the resident's cabinet. LPN #179 looked at the box but did not open it. The outside of the box did not identify what was inside the box. Observation at the time of the interview verified the bipap machine on the bedside table had a mask that was not contained in a bag for sanitation. Interview on 08/13/25 at 6:01 P.M. with the resident included she wore the trilogy two nights ago. Last night it beeped and so she did not wear it. She did not wear it for about a month because of the mask not fitting. The trilogy mask was lying on the bedside table not contained in a bag. Interview on 08/13/25 at 7:00 P.M. with LPN #108 revealed she ordered the new mask on 08/06/25 and it was delivered on 08/07/25. Interview on 08/13/25 at 7:02 P.M. with LPN #179 verified the mask was in the unopened box on top of the resident's cabinet she looked at on 08/11/25. The box did not identify what was in the box. Review of the Treatment Administration Record revealed the device was marked as applied at night on 08/06/25, 08/07/25, 08/09/25, and 08/10/25 when the seal on the old mask was broken. A new mask was ordered 08/06/25, was received 08/07/25 but not opened until 08/11/25. Review of the facility's Oxygen handling policy (updated 01/03/25) included oxygen tubing and other equipment will be changed routinely. Interview on 08/19/25 at 12:03 P.M. with LPN #179 verified the resident had the trilogy machine signed off as being applied when the mask was broken and it would have just beeped because of the bad seal. LPN #179 verified the mask was not applied 08/07/25, 08/08/25, 08/09/25 or 08/10/25 after the new mask arrived and was not opened until 08/11/25. 2. Review of Resident #5's medical record revealed a 07/14/25 readmission with diagnoses including metabolic encephalopathy, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, major depressive disorder, bipolar disorder, constipation, muscle weakness and atrophy, sepsis, vitamin D deficiency, pain, cyst of kidney, osteoarthritis of hip, irritable bowel syndrome with (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diarrhea, hypertension, retention of urine, dysphagia, anxiety, and hypercholesterolemia. A plan of care dated 12/06/21 revealed the resident was at risk for declines/fluctuations in activity of daily living ability related to impaired mobility, metabolic encephalopathy, anxiety, bipolar disease, dyspnea, chronic obstructive pulmonary disease, weakness, chronic respiratory failure, and needs encouraged to get out of bed. Review of the 01/05/22 plan of care indicated the resident was at risk for an alteration in oxygen exchange related to chronic respiratory failure and chronic obstructive pulmonary disease. Physician orders included an order dated 03/18/25 to change oxygen supplies every night shift Sunday, oxy ears to oxygen tubing every shift 01/28/23, oxygen 1-5 LPM via nasal canula, may titrate for shortness of breath 01/31/24, and remove oxygen tubing to check skin on ears every shift 10/10/23. Review of the 07/20/25 Minimum Data Set Assessment included the resident was moderately impaired for daily decision making. The resident needed some help with self care. The resident was set up for eating, and oral hygiene. Resident #5 received continuous oxygen therapy. Observation on 08/11/25 at 12:05 P.M. of Resident #5 revealed her nebulizer machine and mask were on the recliner. The mask was not contained in a bag for sanitation. The mask was face side down on the arm of the recliner. Interview on 08/11/25 at 2:54 P.M. with LPN # 179 verified the resident's nebulizer mask was on the recliner without being contained in a bag for sanitation. The mask was face down on the arm of the recliner. Observation on 08/13/25 at 1:40 P.M. revealed the nebulizer mask was still on the recliner arm and not contained in a bag. 3. Review of Resident #45's medical record revealed an admission [DATE] with diagnoses including acute and chronic congestive heart failure, atrial fibrillation, angina pectoris, type 2 diabetes, obesity, osteoarthritis, and dependence on supplemental oxygen. Physician orders included an order dated 07/14/25 to change oxygen supplies every Sunday night and as needed, an order dated 07/17/25 for oxygen 1-5 LPM via nasal cannula to keep O2 above 88% saturation. A 07/24/25 order for Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) one vial inhale orally every four hours as needed for shortness of breath/wheezing, include assessment, prep time, and administration. Review of the 07/16/25 admission MDS revealed the resident was independent for daily decision making and received oxygen. The resident had a plan of care dated 08/10/25 for potential altered respiratory status/difficulty breathing related to cardiac diagnosis-congestive heart failure atrial fibrillation, generalized edema, and shortness of breath. Observation and interview on 8/11/25 at 10:44 A.M. with Resident #45 revealed the resident was in bed with a patient gown on. She said a gown was easier for her to wear. The resident had oxygen per nasal cannula at 4 1/2 liters per minute without a humidification bottle. The resident said her nose gets dry and it has bled before. She said she was to have a hydration bottle. Interview on 08/11/25 at 2:41 P.M. with LPN #179 verified the resident's oxygen was on at 4 1/2 LPM and she did not have a humidification bottle attached to prevent drying of the nasal cavity.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, dialysis contract review, policy review and interview, the facility failed to ensure ongoing communication with the dialysis center, failed to fulfill the dialysis center contract as agreed upon and failed to ensure dialysis orders were acted upon timely and administered. This affected one resident (#80) of one resident reviewed for dialysis. The census was 68. Findings include: Medical record review revealed Resident #80 was admitted on [DATE] with diagnoses including vertebrae fractures, end stage renal disease, dependence on renal dialysis (hemodialysis), diabetes mellitus, hypocalcemia and depression. Resident #80 was discharged back to the community on 08/18/25. Review of the electronic Physician Orders dated August 2025 revealed Resident #80 was scheduled to have dialysis every Monday, Wednesday and Friday from 6:00 A.M. to 10:00 A.M. Review of the care plan dated 08/07/25 revealed Resident #80 needed hemodialysis related to end stage renal disease. On 08/13/25 at 4:00 P.M., observation revealed Resident #80 was watching television in her room. The resident stated she had gone to dialysis earlier on this day without any problems. Review of the medical record revealed no ongoing communication between the facility and the dialysis treatment center between 08/09/25 and 08/18/25 for Resident #80 when she received hemodialysis. On 08/18/25 at 11:33 A.M., interview with the Assistant Director of Nursing verified there was no facility/dialysis communication for review. Review of the Progress Notes dated 08/08/25 revealed the dialysis center had called the facility and gave new orders as the resident was congested while at dialysis. A written dialysis Progress Note dated 08/08/25 (discovered in Resident #80's discharge paperwork) revealed the dialysis center ordered two new medication including: Calcium acetate (phosphate binder) oral tablet 667 mg two tablets by mouth to be taken with the first bite of each meal. Renvela (phosphate binder) oral tablet 800 (mg) two tablets by mouth to be taken with the first bite of each meal. Review of the medical record revealed the orders for renvela and calcium acetate were not transcribed until 08/12/25. Review of the Pharmacy Packing Slip revealed the renvela 800 (mg) was ordered and delivered to the facility on [DATE] at 11:14 P.M. and Resident #80 received her first dose at the lunch meal on 08/13/25. There was no evidence the pharmacy delivered Resident #80's calcium acetate on 08/12/25, 08/13/25, 08/14/25 or 08/15/25. Review of the Progress Notes dated 08/15/25 revealed the Assistant Director of Nursing (ADON) spoke with the facility pharmacy regarding the resident's order for calcium acetate. The pharmacist stated they do not provide that medication, the ADON notified the dialysis of the above and that the medication had not been administered to date. The dialysis center stated they would be able to send the medications to the facility. Review of the medical record revealed no evidence the dialysis center sent the medications to the facility as indicated in the facility progress note dated 08/15/25. There was no documented evidence of on-going communication between the facility and the dialysis center between 08/15/25 and 08/18/25 regarding the ordered calcium acetate. Review of the electronic Medication Administration Record dated August 2025 revealed calcium acetate was not administered between 08/08/25 when the order was originally sent to the facility from the dialysis center through discharge on [DATE]. On 08/18/25 at 12:15 P.M., interview with the Director of Nursing (DON) verified the facility did not receive calcium acetate 667 (mg) as ordered by the dialysis center for Resident #80. The DON verified the order was not transcribed when received on 08/08/25 until 08/12/25 and it took three days before follow-up with the facility pharmacy as to why it had not been delivered and no calcium acetate was received from the dialysis center to administer. Review of Nursing Home Dialysis Transfer Agreement dated 01/25/19 revealed the following: Each party shall secure and maintain, or cause to be secured and maintained during the term of this Agreement, separate policies for comprehensive general liability, covering bodily injury and property damage, and professional liability insurance; each policy shall provide minimum limits of liability of \$1,000,000 per occurrence and \$3,000,000 in the aggregate. Each party shall also secure and maintain, or cause to be secured (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and maintained during the term of the Agreement, automotive insurance providing a minimum limit of liability of \$1,000,000 in the aggregate. Each party shall carry and maintain throughout the contract term worker's compensation and employer's liability insurance or any alternative plan or coverage as permitted or required by applicable laws within the state of Ohio with a minimum employers' liability limit of \$1,000,000 each accident, each employee for disease, and policy limit for disease. Each party shall name the other party as an additional insured on the insuring party's general liability policy. Each party shall deliver to the other party certificate(s) of insurance evidencing such insurance coverage upon the request of the other party. Each party shall provide the other party with not less than thirty days prior written notice of any change in or cancellation of any of such insurance policies. Said insurance shall survive the termination of this Agreement. Review of the Certificate of Liability Insurance dated 12/27/24 through 12/27/25 revealed no evidence the dialysis center was named as an additional insured general liability policy per contractual agreement. On 08/18/25 at 2:20 P.M., interview with the Administrator stated she was contacting corporate as the dialysis center was not on the general liability policy per the signed contract. On 08/19/25 at 11:08 A.M., interview with the Administrator stated the facility did not have an insurance general liability policy identifying the above per the signed Dialysis Transfer Agreement. Review of the Dialysis policy (revised April 2025) revealed the facility will implement processes that strive to ensure the comfort, safety and appropriate management of the hemodialysis resident. The facility would also maintain the contractual agreement with the dialysis center.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, job description review and interview, the facility failed to timely provide psychiatric services as indicated by mood symptoms. This affected one resident (#46) of five residents reviewed for unnecessary medications. The census was 68. Findings include: Medical record review revealed Resident #46 was admitted on [DATE] with diagnoses including cerebral infarction, intracerebral hemorrhage, bipolar disorder, depressed mild or moderate severity and anxiety disorder. Review of the electronic Physician Orders dated August 2025 revealed Resident #46 was receiving Abilify (antipsychotic) 5 milligrams (mg) at bedtime, prozac (antidepressant) 30 (mg) in the morning, trazodone (antidepressant) 150 (mg) at bedtime, lamictal 100 (mg) for mood stabilization and buspirone (anxiolytic) 15 (mg) three times a day for anxiety. Review of the care plan: Potential to have Mood Problem related to chronic obstructive pulmonary disease, cognitive communication deficit, depression, bipolar and anxiety dated 04/23/25 and revised 05/08/25 revealed a goal to have an improved mood state. Interventions included to administer medication as ordered; behavioral health consults as needed and monitor/record mood to determine if problems seem related to external causes; and assist the resident, family and caregivers to identify strengths, positive coping skills and reinforce these. Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed the following: Resident #46 was cognitively intact for daily decision-making, had seven to 11 days having trouble falling or staying asleep, depressed, or hopeless; and often social isolates. Review of the 5-day MDS assessment dated [DATE] revealed the following: Resident #46 had 12 to 14 days with little interest or pleasure in doing things, seven to 11 days having trouble falling or staying asleep; and always social isolates. Review of the quarterly MDS assessment dated [DATE] revealed the following: Resident #46 had two to six days with little interest or pleasure doing things; had seen to 11 days with feeling down, depressed or hopeless; and had 12 to 14 days trouble falling asleep, staying asleep or sleeping too much. Review of the medical record revealed no evidence Resident #46 had been seen or evaluated by the facility psychiatrist/behavioral health physician between 04/17/25 and 08/05/25. Review of the psychiatrist Initial Visit Progress Note dated 08/06/25 revealed the visit was for medication management for depression and psychiatric evaluation. Mental status was pleasant cooperative, mood euthymic with appropriate affect, denied suicidal or homicidal ideation or intent or any psychotic symptoms. Fair insight and judgement into her problem. Assessment included bipolar disorder with a plan to decrease Abilify to 5mg daily, continue other medication and continue to monitor efficacy and side effects to medication. Continue to follow. On 08/18/25 at 7:50 A.M., observed Resident #46 in the dining room eating breakfast with no behavioral health concerns identified. On 08/19/25 at 3:02 .P.M. observed Resident #46 ambulating independently with walker with her daughter. No behavioral health concerns were identified. On 08/20/25 between 9:10 A.M. and 9:16 A.M. interview with Social Worker (LSW) #171 revealed Resident #46 was diagnosed with bipolar disorder, depression and had traumatic life experiences from previous marriages. LSW #171 stated Resident #46 had been missed and had not seen the psychiatrist since admission until 08/06/25. She discovered this when reviewing Resident #46 during her comprehensive assessment and verified her mood indicators had fluctuated since admission. LSW #171 verified the resident should have been seen by psych services that came to the facility the first of every month. LSW #171 verified the resident also had not received any counseling sessions during her stay at the facility stating she was not a trained counselor. LSW #171 did not know how she missed getting the resident seen by psych services and actually the resident had several MDS assessment reviews with mood indicators that should have been addressed. LSW #171 verified the plan of care was not followed, the resident voiced concerns to her during the assessment that was not shared with the nursing staff; the resident was on multiple medications for bipolar and depression (continued on next page)		

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the psychiatrist decreased once the resident was evaluated. On 08/20/25 at 10:50 A.M. interview with LSW #171 stated upon admission an assessment is completed that flows over to the care plans regarding trauma triggers and how to prevent triggers. LSW #171 stated this was all that she does for trauma triggers and the resident has not had any since admission that she was aware of. Review of the Social Service Director Job Description signed 04/17/23 revealed the primary purpose of the job position was to assist in planning developing organizing implementing evaluation and directing social services programs in accordance with current existing federal state and local standards as well as our established policies and procedures to assure that the medically related emotional and social needs of the resident are met maintained on an individual basis. Essential Job Functions and Responsibilities included work with emotional problems including assisting resident/family with anxieties and stress caused by illness and admission to the facility, difficulties in coping with residual physical disabilities, fears related to helplessness and death and the need for institutional and specialized care. Assist in interpreting social, psychological and emotional needs of the resident/family to the other resident care team members.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and policy review the facility failed to ensure expired insulin was discarded. This affected one resident (#77) of three residents with insulin pens observed in the 200-medication cart. The facility census was 68. Findings Include: Medical record review revealed Resident #77 was admitted to the facility on [DATE] from a sister facility with diagnoses including diabetes, heart disease, and chronic kidney disease. Review of Resident #77 orders dated 08/2025 revealed Humalog Kwikpen subcutaneous pen injector inject per sliding scale before meals. There was no evidence the resident was ordered Novolog. Review of Resident #77 Medication Administration Records (MAR) revealed Resident #77 received Humalog per sliding scale 11 times from [DATE] to [DATE]. Observation on [DATE] at 8:32 A.M., of the 200-medication cart with Licensed Practical Nurse (LPN) #149 revealed Resident #77 had three Humalog pens. One Humalog pen was not opened and two were opened and dated they were opened [DATE]. The label indicated to throw away any medication that remains 28 days after first use. The LPN confirmed the insulin was not refrigerated after it was opened. There was also a Novolog pen for Resident #77 that indicated the used by date was [DATE]. LPN #149 confirmed the two Humalog pens opened [DATE] would have expired 28-30 days after they opened and should have been discarded around [DATE]. The LPN confirmed the used by date on the Novolog was [DATE]. Interview on [DATE] at 8:52 A.M., with the Director of Nursing (DON) and Corporate Regional Nurse (CRN) #193 revealed Resident #77 was a resident in the facility, however, was transferred to a sister facility for intravenous therapy and returned back to the facility on [DATE]. The sister facility had sent the Humalog and Novolog back with the resident and the Humalog should have been discarded 28 days after being opened and the Novolog should have been discarded on [DATE]. The Novolog came from the hospital, and the hospital dates when it expires not when it was opened. Interview on [DATE] at 9:20 A.M., LPN #179 confirmed Resident #77 had received the sliding scale Humalog 11 times from [DATE] to [DATE]. The LPN confirmed the resident did not have an order for Novolog and it should have been disposed of due there was no order, and it had expired on [DATE]. Review of the facility policy titled Medication Storage (dated 04/2018 and updated [DATE]) revealed the nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Review of facility's policy titled Insulin Pen labeling and Packaging (undated) revealed the insulin pens to be individually labeled and placed in a re-closeable plastic bag to control the spread of infection. Review of the facility Insulin Pen Reference Guide revealed Humalog pen can be used at room temp for 28 days.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review and interview, the facility failed to adequately monitor for appropriate use of opioids. This affected one resident (#67) of five residents reviewed for unnecessary medications. The census was 68. Findings include: Medical record review revealed Resident #67 was admitted on [DATE] with diagnoses including osteoarthritis, spinal stenosis cervical region, arthrodesis status, traumatic subdural hemorrhage without loss of consciousness and muscle wasting. Review of Resident #67's care plan: Risk for Pain related to osteoarthritis, diabetes mellitus, GERD, chronic kidney disease, spinal stenosis, diverticulosis, previous subdural hemorrhage and atherosclerosis of aorta revised 04/11/25 revealed to administer analgesia per orders, anticipate the resident's need for pain relief and respond immediately for complaints of pain. Review of the care plan did not include any individualized non-pharmacological interventions for pain management. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #67 was cognitively intact for daily decision-making, received PRN (as needed) pain medication and opioids for complaints of pain. The resident indicated he had occasional pain with the worst pain experienced in the previous five days of the assessment being moderate pain. Review of the electronic monthly Physician Order dated August 2025 revealed to administer oxycodone HCL 5 milligrams (mg) one tablet as needed (PRN) for moderate to severe pain. There was no physician parameters provided of what numerical scale indicated moderate or severe pain. Review of the electronic Medication Administration Record (MAR) dated March 2025 revealed oxycodone HCL 5 (mg) was administered for the following pain rating: a. On 03/03/25, pain rated a zero out of 10. b. On 03/07/25, pain rated a two out of 10. c. On 03/19/25, pain rated a four out of 10. d. On 03/06/25 and 03/08/25, pain rated a five out of 10. e. On 03/01/25, 03/05/25, 03/10/25, 03/12/25, 03/13/25 and 03/17/25, pain rated a six out of 10. f. On 03/18/25, pain rated a seven out of 10. g. On 03/05/25 and 03/15/25, pain rated an eight out of 10. 2. Review of the MAR dated April 2025 revealed oxycodone HCL 5 (mg) was administered for the following pain rating: a. On 04/03/25, pain rated a three out of 10. b. On 04/02/25, 04/05/25, 04/14/25, 04/16/25 and 04/19/25 pain rated a four out of 10. c. On 04/06/25, 04/11/25, and 04/24/25, pain rated a five out of 10. d. On 04/04/25, 04/05/25 and 04/22/25, pain rated a six out of 10. e. On 04/08/25 and 04/23/25, pain rated a seven out of 10. 3. Review of the MAR dated June 2025 revealed oxycodone HCL 5 (mg) was administered for the following pain rating: a. On 06/01/25, 06/07/25 and 06/11/25, pain rated four out of 10. b. On 06/03/25, pain rated six out of 10. c. On 06/12/25, pain rated eight out of 10. 4. Review of the MAR dated August 2025 revealed oxycodone HCL 5 (mg) was administered for the following pain rating: a. On 08/06/25 and 08/10/25, pain rated four out of 10. b. On 08/09/25, pain rated five out of 10. c. On 08/05/25, pain rated six out of 10. d. On 08/01/25, 08/04/25 and 08/13/25, pain rated seven out of 10. e. On 08/02/25, pain rated eight out of 10. On 08/12/25 at 6:00 P.M. and 6:45 P.M., interview with Licensed Practical Nurse (LPN) #108 stated pain was subjective and the numerical system could mean different things to different nurses. LPN #108 stated to her, a pain rated a six or seven would be what she considered to be moderate and an eight to 10 would be severe. LPN #108 stated her interpretation of moderate or severe pain could be different than what the resident's interpretation was too. There were no parameters that would consistently ensure all nurses were administering oxycodone as ordered by the physician. LPN #108 stated the facility used to have a numerical scale to indicate when to administer medications for pain but that changed at some point but can't remember how long ago that was. On 08/13/25 at 5:29 P.M., interview with the Director of Nursing (DON) revealed the nurses monitor resident pain by assessing and interviewing the resident if they can verbally state their pain level; otherwise, assess by use of a non-verbal scale. The DON verified Resident #67's oxycodone HCL order did not include a numerical scale indicating what moderate and severe pain was. The DON verified the current orders were subjective and could be interpreted differently for one or another person. The DON was unable to (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	state what described mild, moderate or severe when given a pain numerical scale. Review of the facility Pain policy (revised 01/01/25) revealed the purpose was to help the staff identify pain in the resident and to develop interventions that were consistent with the resident's goals and needs and that address the underlying causes of pain. The resident's pain and consequences of pain was to be assessed at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. Non-pharmacological interventions may be appropriate alone or in conjunction with medications including environmental, physical, exercise, cognitive or behavioral, pharmacological interventions.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital discharge orders, and interview the facility failed to ensure laboratory testing was performed per orders. This affected one resident (#82) of six residents reviewed for medication review. Findings Include: Closed medical record review revealed Resident #82 was admitted to the facility on [DATE] and discharged on 06/30/25 with diagnoses including osteomyelitis, diabetes, methicillin susceptible staphylococcus aureus, and absence of left foot. Review of Resident #82's discharge hospital notes dated 06/16/25 revealed orders for the following laboratory work: weekly complete blood count (CBC), basic metabolic profile (BMP), and creatine Kinase (CK) weekly until 07/16/25. Review of Resident #82's medical record revealed no evidence a CBC, BMP, or CK was performed. Interview via email on 08/19/25 at 8:46 P.M., with Corporate Regional Nurse (CRN) #193 confirmed the resident did not have weekly labs per discharge orders. Interview on 08/20/25 at 9:00 AM with Licensed Practical Nurse (LPN) #179 confirmed the resident was ordered weekly labs on admission, however they were not completed.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of infection control log, interview, and policy review the facility failed to ensure residents met criteria for antibiotic treatment. This affected two residents (#1 and #83) of four residents reviewed for antibiotic stewardship. Findings Include: 1. Closed medical record review revealed Resident #83 was admitted to the facility on [DATE] with diagnoses including sepsis of unspecified organism, metabolic encephalopathy, diabetes, respiratory failure, heart disease, and pressure ulcer. Review of Resident #83's orders revealed on 06/01/25 the resident was ordered Cefdinir 300 milligrams (mg) by mouth twice daily for wound infection. On 06/03/25 the order was changed to Cefdinir 300mg by mouth twice daily for sepsis, likely respiratory until 06/05/25. Review of Resident #83's Medication Administration Record (MAR) dated 06/20/25 revealed Resident #82 received Cefdinir 300 mg from 06/01/25 to 06/03/25 for wound infection and from 06/03/25 to 06/05/25 for sepsis, likely respiratory. Review of the infection control log dated 06/20/25 revealed Resident #83 was marked under other for infection, the organism was sepsis, the onset was 06/01/25, the resident received Cefdinir and not applicable was marked for the antibiotic stewardship. Review of Resident #83's McGeer criteria form dated 06/01/25 revealed a line was marked out across the page and a handwritten note indicating there was no criteria for sepsis. Review of Resident #83's hospital record dated 06/01/25 revealed sepsis unclear. Chest x-ray and urine negative for infection, COVID, influenza, Respiratory Syncytial Virus (RSV), Respiratory Pathogen Panel (RPP) negative. Blood cultures 05/27/25 possible contaminated, MRI/CT spine showed no infection. Cefdinir for five days on discharge. Interview on 08/14/25 at 8:57 A.M., with Licensed Practical Nurse (LPN)/Infection Preventionist (IP) #179 and Regional Corporate Nurse (RCN) #193 confirmed Resident #83 did not meet criteria of antibiotic treatment. The LPN/IP #179 confirmed there was no documented evidence why the resident needed antibiotic treatment. 2. Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including osteomyelitis, diabetes, UTI, heart failure, bacteremia, and hemiplegia. Review of Resident #1's orders dated 07/07/25 revealed orders for Metronidazole 500 mg one every eight hours for osteomyelitis for 18 days and Vancomycin 1750 mg intravenously in the evening for wound infection for 18 days. Review of Resident #1's MAR dated 07/2025 revealed Resident #1 received Metronidazole 500 mg one every eight hours for osteomyelitis for 18 days and Vancomycin 1750 mg intravenously in the evening for wound infection for 18 days. Review of the infection control log dated 07/2025 revealed Resident #1 received Metronidazole and Vancomycin for a joint infection (osteo) and N/A was marked if the McGeer criteria was met. Interview on 08/14/25 at 8:57 A.M., with Licensed Practical Nurse (LPN)/Infection Preventionist (IP) #179 and Regional Corporate Nurse (RCN) #193 confirmed Resident #1 was marked N/A if he met criteria and both antibiotics on the infection control log. The IP reported osteomyelitis was not one of the criteria she checks to ensure antibiotics were appropriate due to it not being on the form the facility was utilizing. Review of the facility McGeer criteria form undated revealed only areas on the form were urinary tract infections (UTI), respiratory, skin and soft tissue, and gastroenteritis to ensure residents met criteria for antibiotic treatment. Review of June's 2025 infection control log revealed there were ten residents marked N/A and four no for the McGeer criteria that received antibiotics. Review of the July 2025 infection control log revealed there were seven residents marked N/A, one blank, and one no for the McGeer's criteria that received antibiotics. Review of the August 2025 infection control log dated 08/01/25 to 08/06/25 revealed there were two residents marked no for the McGeer's criteria that received antibiotics for skin and UTI. Interview on 08/14/25 at 10:15 A.M., with RCN #183 confirmed the facility antibiotic stewardship program only had the McGeer Criteria for urinary tract infections (UTI), respiratory, skin and soft tissue, and gastroenteritis. If the infection doesn't fall under those categories, the facility document as not applicable (N/A) on the log, and the IP doesn't ensure the resident meets criteria for treatment per the (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CDC guidelines and facility's policy. The RCN #183 confirmed the CDC had criteria for osteomyelitis; however, osteomyelitis was not on the facility's criteria worksheet therefore the IP would just mark N/A on the infection control log if the resident met criteria for McGeer's. Review of the CDC criteria for antibiotic treatment dated 01/2025 revealed osteomyelitis must meet at least one of the following criteria: 1. Patient has organism(s) identified from bone by culture or non-culture based microbiological testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST). 2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam. 3. Patient has at least two of the following localized signs or symptoms: fever (>38.0 C), swelling*, pain or tenderness*, heat*, or drainage* And at least one of the following: a. organism(s) identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST). AND imaging test evidence definitive for infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician or physician designee documentation of antimicrobial treatment for osteomyelitis. b. imaging test evidence definitive for infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivalent. Review of the antibiotic stewardship policy dated 12/23 and updated 05/25 revealed the Centers of Disease Control (CDC) had reported that antibiotic resistance was one of the major threats to human health, especially because some bacteria have developed resistance to all known classes of antibiotics. According to CDC, improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotics resistance is a national priority. Disease caused by these bacteria are increasing in long-term care facilities and contributing to higher rates of morbidity and mortality. This policy is aligned with the CDC Core Elements of Antibiotic Stewardship for Nursing Homes. The antibiotic stewardship team would review infections and monitor antibiotics usage patterns on a quarterly basis. The infection preventionist will collect and review data such as type of antibiotic ordered, route of administration, whether the order was made by phone, if the order was given by attending physician or on call doctor. whether appropriate tests such as cultures were obtained before ordering antibiotics, whether the antibiotic was changed during treatment. Review of the Infection Control Prevention Policy dated 04/19 and revised 01/11/25 revealed the facility infection prevention program was comprehensive in that it addresses detection, prevention, and control of infections among residents and employees. A systemic and organized data-driven methods is in place to prevent infections, track existing infection, track and trend for in-house infections, surveil for outbreaks for effectiveness and timely implementations of appropriate interventions and monitor infection control practices for compliance. The facility will utilize current CDC guidelines for current infections control monitoring and guidance. In the absence of clear policy directions, the facility would utilize the CDC website as a standard for reference and directions. The goal of the facility infection prevention program are to reduce the spread of infectious disease within the facility, improve antibiotic stewardship, decrease infection, comply with federal, state, and local community disease, investigate outbreaks, identify and correct problems, and Maintain compliance with state and federal regulation relating to infection preventions.		