STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366286	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Cedar Hill	1136 Adair Avenue 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to ensure Resident #54 received necessary services to maintain good oral hygiene. This affected one (Resident #54) of three residents reviewed for activities of daily living (ADL) care. The facility census was 71. Findings include:Review of Resident #54's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included major depressive disorder, muscle weakness, unsteadiness on his feet, abnormalities of gait and mobility, and the need for assistance with personal care. Review of Resident #54's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. He was not known to display any behaviors, nor was he known to reject care. He was coded as being dependent on staff for oral hygiene. He was indicated to be edentulous with no natural teeth or tooth fragments noted. Review of Resident #54's care plans revealed he had a care plan in place for an ADL self care deficit. The care plan was initiated on 11/09/22 and was last revised on 09/16/25. The interventions included encouraging the resident to participate to the fullest extent possible with each interaction. The care plan did not list each ADL care out separately and was not specific to the provision of oral hygiene care. Further review of Resident #54's care plans revealed he also had a care plan in place for having oral/ dental health problems related to being edentulous. The goal was for the resident to successfully manage/ receive assistance with mouth care at least daily. The interventions included the need to coordinate arrangements for dental care. The interventions did not specifically include the provision of oral hygiene care as one of the interventions to be followed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/25 at 2:45 P.M., an interview with Resident #54 revealed he did not receive any assistance with his oral hygiene care. He confirmed he did not have any natural teeth and did not use dentures. He stated he would have liked to be provided with mouthwash and a mouth swab to use when performing oral hygiene care. He stated he would be able to do that for himself if he had the supplies and the staff provided set up help. He denied the staff had offered any of those supplies to him. On 11/26/25 at 10:55 A.M., an interview with Certified Nursing Assistant (CNA) #177 revealed she believed Resident #54 had his own natural teeth. She reported he did not have them all, but had a few. CNA #177 stated the nursing staff provided Resident #54 with oral hygiene care, or at least sat by him so he could do his own oral care which she thought included only mouth wash for residents who had no natural teeth nor dentures. During this interview CNA #177 proceeded to go to Resident #54's room to check his mouth to see if he had any natural teeth, as she previously stated. CNA #177 verified Resident #54 was edentulous with no natural teeth or tooth fragments present and did not have the use of dentures. CNA #177 confirmed after checking in Resident #54's bathroom that there was no evidence of mouth swabs or mouthwash available for mouth care. CNA #177 asked Resident #54 if he would like her to get some supplies to do mouth care and Resident #54 stated that would be nice. CNA #177 went to the central supply room and got the resident mouth swabs and a bottle of mouthwash for him to use when receiving oral hygiene care. CNA #177 stated oral hygiene care should be provided as part of the resident's morning care. CNA #177 stated she did not know why there were no oral hygiene supplies in Resident #54's room. CNA #177 verified that prior to looking in Resident #54's mouth during the interview, she did not know he was edentulous. Review of the facility's policy on Oral Hygiene updated 11/05/24 revealed the facility recognized the importance of good oral hygiene practice to cleanse mouth, teeth, and dentures. It was to be provided to prevent infection, irritation, periodontal disease and odors. The policy only included directives for residents who had their own teeth and/ or dentures. It did not address residents who did not have any of their natural teeth (edentulous) and/ or the use of dentures. This deficiency represents non-compliance investigated under Complaint Intake Number 2665757.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review and interview the facility failed to follow physician orders to apply ice packs several times a day to the left knee of Resident #72 who was status post left total knee replacement. This affected one (Resident #72) of three residents reviewed for admission and post-surgical physician orders. The facility census was 71. Findings Include:Findings Include:Review of the medical record for Resident #72 revealed an admission date of 10/16/25 after having a left total knee replacement on 10/13/25. Resident #72's diagnoses included diabetes, anemia, heart disease, high blood pressure and gastric reflux.Review of the initial nursing assessment completed on 10/16/25 revealed Resident #72 had a brief interview for mental status score of 14/15, meaning the resident was cognitively intact. Review of the Minimum Data Set (MDS) 3.0 assessment revealed Resident #72 was dependent for toileting, substantial assistance for dressing lower body, and dependent on applying foot wear. Review of the hospital After Visit Summary (AVS) printed on 10/16/25 at 9:14 A.M. and provided by the medical transport team to the facility on admission revealed Resident #72 was ordered post-operative care and treatment to include ice packs to operative leg several times a day 10 to 20 minutes on and 10 to 20 minutes off to decrease pain and swelling.Review of the Treatment Administration Record (TAR) for Resident #72 revealed on 10/20/25 ice packs to be applied to operative site to aide in decreasing pain and swelling. This should be done multiple times a day 10 to 20 minutes on and 10 to 20 minutes off. Place barrier, such as towel between ice and skin, four times a day for pain and swelling. The treatment was signed off as completed only once on 10/20/25 at 8:00 P.M.Further review of the medical record for Resident #72 revealed on 10/20/25 the Resident/Resident Representative requested a transfer to another skilled rehabilitation facility. On 10/21/25 Resident #72 was discharged from the facility, and his daughter transported him to another facility for further care and treatment.Interview on 11/25/25 at 9:05 A.M. with Resident #72's daughter revealed on 10/20/25 she reported to facility administration that Resident #72 had not received any ice packs or application of ice packs since arrival on 10/16/25 and it was ordered on the AVS from the hospital.Interview on 11/25/25 at 3:05 P.M. with licensed practical nurse (LPN) #125 revealed she recalled admitting Resident #72 to the facility on [DATE] between 11:30 A.M. and 12:00 P.M. LPN #125 reported that Resident #72 had a knee replacement. Interview with LPN #125 further revealed she received the AVS from the transporting team and reviewed it. LPN #125 reported she reconciled the AVS orders with the nurse practitioner around 1:30 P.M. and then entered them into the computer system. LPN #125 did not recall an order for ice pack application and stated if its not in the computer then it wasn ' t on the AVS. Interview on 11/26/25 at 3:45 P.M. with the Director of Nursing (DON) revealed she was notified by the daughter of Resident #72 on 10/20/25 that he had not received ice to operative knee since admission and the ice application was ordered on the AVS. The DON further explained that the AVS was reviewed, and an order was placed immediately, and ice application was offered to Resident. The DON could not explain why the ice application was only marked once on the treatment record as completed on 10/20/25 at 8:00 P.M. The DON further reported the facility began a self-imposed action plan on 10/22/25 due to the ice not being implemented as ordered upon admission. The deficient practice was corrected on 11/20/25 when the facility implemented the following corrective actions:-Chart audits were completed for all new admissions dated 10/01/25 through 10/22/25 and then for an additional four weeks ending on 11/20/25. The audits were completed to review resident discharge orders to the orders entered on admission to the facility for accuracy and correction if needed. Audit details included: admission orders matching the discharge orders including the Medication Administration Records and TAR orders, completion of the admission checklist, and verification of two nurses for admission orders.-All nursing staff were educated on the expected admission process, utilizing the admission checklist, and having two nurses review admission orders for accuracy.-The concern involving Resident #72 and follow-up actions taken was added to the quality assurance and performance improvement committee meeting agenda for review.As of the date of the survey on 11/26/25 no further non-compliance was identified pertaining to following admission and post-surgical physician orders. This deficiency represents non-compliance investigated under Complaint Number 2650857.