

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Cedar Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure one resident (#70) with cognitive impairment was supervised while leaving the facility resulting in a fall in the parking lot. This affected one resident of seven reviewed for accidents. The facility also failed to ensure fall prevention interventions were implemented as care planned for Resident #10 and #29. The facility census was 79. Findings Include: 1. Review of Resident #70's medical record revealed an admission date of 03/30/26 with diagnoses that included acute diastolic (congestive) heart failure, Type II Diabetes Mellitus without complications, schizoaffective disorder, depression, anxiety and repeated falls. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed moderate cognitive impairment. He had no impairment to his upper or lower extremities and required partial to moderate assistance with ambulation. Review of the fall risk assessment dated [DATE] revealed he was at moderate risk for falls. Review of the care plan for Resident #70 dated 04/03/26 revealed he had an Activities of Daily Living (ADL) self-care performance deficit related to high-risk medication, falls, schizophrenia and depression. Interventions included resident transfers with physical assist of one staff member. Review of the care plan dated 03/30/26 revealed Resident #70 was at high risk for falls and potential injury related to history of falls and high-risk medication use. Interventions included education provided to sign out with nurse when going outside dated 06/22/26. Review of the facility fall investigation dated 06/22/26 at 8:45 A.M., Resident #70 was seen by assisted living staff falling in the parking lot. He stated he was going to the gas station and complained of right hip and right shoulder pain and was subsequently sent to the emergency room. He returned to the facility on [DATE] and suffered superficial abrasions. Interview on 06/30/26 at 10:33 A.M. with Director of Rehab #168 revealed at the time of Resident #70's fall according to his therapy Discharge summary dated [DATE], his balance was fair with the use of a rollator, transfers was moderate to supervision with assistive device/rollator, he ambulated 100-200 feet with a rollator and required standing recovery periods and supervision due to shortness (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of breath. He should have been supervised with ambulation and he was not safe to leave the building on his own. Interview on 06/30/26 at 11:03 A.M. with Certified Nursing Assistant (CNA) #164 revealed Resident #70 should not go outside unsupervised, he would get short of breath walking to the bathroom. CNA # 164 verified the Kardex for Resident #70 stated th resident required physical assist of one person. 2. Review of the medical record for Resident #10 revealed an admission date of 09/09/16 with diagnoses including cerebral infarction, syncope and collapse, anxiety disorder, nontraumatic subdural hemorrhage, traumatic subdural hemorrhage with loss of consciousness, dementia and age-related osteoporosis without current pathological fractures. Review of Resident #10's care plan dated 02/26/21 revealed she was at risk for falls and potential injury related to dementia, decreased safety awareness and syncope and collapse. She will take self to bathroom without using the call light for assistance. Interventions included but not limited to bright colored tape to call light dated 03/25/26. Review of the facility fall investigation dated 03/25/26 at 6:00 A.M. revealed Resident #10 fell out of bed and received a skin tear to left arm. Intervention added bright colored tape to call light. Subsequent review of Resident #10's medical record revealed a progress note dated 03/25/26 at 6:56 A.M., resident fell out of bed and was seen lying on left side partially under bed. She complained of pain to the left hip and was transferred to the emergency room for evaluation. She returned on 03/27/26 with no injuries. Review of the fall risk assessment dated [DATE] revealed Resident #10 was at high risk for falls. Observation and interview on 06/28/26 at 10:47 A.M. of Resident #10's call light wrapped around her grab bar on the bed near the wall and resident unable to reach it. No bright colored tape was observed on the call light. Licensed Practical Nurse (LPN) # 654 verified resident could not reach her call light and no bright colored tape to the call light. 3. Review of Resident #29's medical record revealed an admission date of 07/31/22, a re-entry date of 06/28/24 and diagnoses including fracture of upper end of right humerus, dementia, chronic diastolic (congestive) heart failure, chronic kidney disease stage five, paroxysmal atrial fibrillation, Alzheimer's disease, anxiety disorder, and hypertension. Review of Resident #29's fall care plan initiated 08/09/22 revealed the resident was at risk for falls related to gait and balance problems and had an intervention dated 08/29/25 for grip strips to the floor on bilateral sides of the bed. Review of Resident #29's quarterly Minimum Data Set (MDS), dated [DATE] revealed a brief interview for mental status score of nine indicating the resident had moderate cognitive impairment. Further review of the MDS revealed the resident utilized a walker and a wheelchair for mobility and required partial/moderate assist with toileting hygiene and was occasionally incontinent of bladder. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of Resident #29's room on 06/30/26 at 10:20 A.M. revealed there were no grip strips on the floor in the resident's room. An observation of Resident #29's room on 06/30/26 at 10:30 A.M. revealed there were no grip strips on the floor in the resident's room. In an interview on 06/30/26 at 10:30 A.M. the Director of Nursing (DON) verified the grip strips were not on the floor as indicated on the care plan. In an interview on 06/30/26 at 10:45 A.M. Licensed Practical Nurse (LPN) #454 stated she had seen Resident #29 kick at or scuff his foot over the strips when they were on the floor but had not seen him try to remove them. In an interview on 06/30/26 at 10:50 A.M. Certified Nursing Assistant (CNA) #159 stated she had not seen Resident #29 try to remove the grip strips from his floor and was not aware that they were not on the floor. In an interview on 06/30/26 at 10:55 A.M. Housekeeper #365 stated Resident#29 was usually out of his room when she cleaned it so she had not seen him try to remove the strips. Housekeeper #365 further stated she had not even noticed that the strips were not in place when she cleaned his room earlier that morning. In an interview on 07/01/26 at 9:25 A.M. the Regional Maintenance Director stated the grip strips had been on the floor and there was no way the resident would have been able to remove them as they are very sticky and require a utility knife or scrapper to get them off of the floor. Review of the facility policy titled Fall Policy dated August 2025, revealed it is the policy of this facility to assure proper review of resident fall risk and implementation of interventions to attempt to prevent or reduce falls/accidents and injuries related to falls.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, product information review, and policy review, the facility failed to ensure multi-use insulin vials and insulin flex pens stored in the medication administration carts were properly dated, stored, and/or discarded when needed. This affected four residents (Resident #9, #35, #68, and #70), who had their insulin stored in the medication administration cart for the East Back Hall. The facility also failed to ensure medications were stored securely, this affected three resident (#35, #12 and # 65), who were observed to have medication/wound treatment at the bedside. This had the potential to affect four residents (Resident #13, #36, #67, and #73) on the East Hall and five residents, (#2, #25, #34, #48, and #57) on the secured behavioral unit who were cognitively impaired and identified as independent with ambulation or mobile in wheelchairs. The facility census was 79. Findings include: 1.) On 07/01/26 at 10:35 A.M., an observation was made of the East Back Hall medication administration cart for the proper storage and labeling of medications. Registered Nurse (RN) #160 was present and observed the surveyor go through the medication cart looking for any unlabeled or expired medications. Several insulin vials and one insulin flex pen were found in the small pull out drawer on the upper right side of the medication cart that were not dated when first accessed, not stored in the refrigerator before being first accessed, or had not been discarded after 28 days of being used as required. Findings as followed: 1 a.) Resident #70 was noted to have a multi-use vial of Lantus (slow acting insulin injection) 100 units/ milliliter (ml) in the top of the medication administration cart that had an access date of 05/12/26. The Lantus was not discarded after 28 days following first use as required. Findings were verified by RN #160. 1 b.) Resident #9 was noted to have a multi-use vial of Lantus 100 units/ ml in the top drawer of the medication administration cart that had been accessed with no date when that first access occurred. Findings verified by RN #160. An interview with RN #160 at the time of the observation confirmed, without a date indicating when the vial was first accessed, they would not know when the vial needed to be discarded. She believed they had 28 days or so that the vial could be used, after being first accessed, and when needing to discard the remainder of the medication being stored at room temperature. 1 c.) Resident #35 was noted to have a vial of Insulin Lispro (fast acting insulin injection) 200 units/ ml in the top drawer of the medication administration cart. There was a date that indicated the vial was first accessed on 05/12/26. Findings were verified by RN #160. She confirmed the insulin had not been discarded after 28 days of it first being used. 1 d.) Resident #68 was noted to have a Novolog Flex pen stored in the top of the medication administration cart. The flex pen had not been used and there was no date to indicate when it had been removed out of the refrigerator. The plastic bag the flexpen was stored in provided instructions to refrigerate until used. Findings were verified with RN #160 that the flexpen should have been stored in the refrigerator until used. Review of a package insert that came with the Lantus insulin revised May 2025 revealed, after Lantus vials had been opened (in-use) they could be stored in the refrigerator between 36 degrees Fahrenheit (F.) to 46 degrees Fahrenheit (F). or at room temperature below 86 degrees F. for up to 28 days. The Lantus bottle being used should be thrown away after 28 days, or if the expiration date has passed, even if it still had insulin left in it. The facility denied they had any product information that was sent to them from the pharmacy for the Insulin Lispro. Review of drug information from MedScape for Insulin Lispro revealed the 3 ml Solostar pens (flexpens) should be refrigerated at 36- 46 degrees F. until the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expiration date or at room temperature for up to 28 days. Opened (used) 3 ml flexpens should be stored at room temperature (less than 86 degrees F.) for up to 28 days. 2. Review of the medical record for Resident #35 revealed an admission date of 06/12/21 with diagnoses including heart failure, Type II Diabetes Mellitus, generalized anxiety disorder, major depressive disorder, and mild cognitive impairment. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively intact. Observation on 06/29/26 at 9:29 A.M. of medications on bedside table in a cup crushed in applesauce. Review of the physician orders revealed Resident #35 did not have an order to self-administer medications or for medications to be left at bedside. Interview on 06/29/26 at 9:35 A.M. with Licensed Practical Nurse (LPN) # 256 revealed she prepared Resident #35's medications. LPN #256 confirmed she left the medications on the bedside table and further confirmed Resident #35 does not have an order for self-administration or for medications to be left at bedside. Review of the updated facility policy titled Administration and Documentation of Medications dated April 2026, revealed it is the policy of this facility that every resident receives medications by a licensed nurse as prescribed by a licensed physician or other healthcare provider legally permitted to prescribe medications safely, properly and in a timely manner, and that medications shall be accurately and completely documented. 3. Review of Resident #12's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, major depressive disorder, conduct disorder, history of suicidal ideations, adult-onset diabetes mellitus, obstructive and reflux uropathy, and chronic osteomyelitis (bone infection) of the left foot and ankle. Review of Resident #12's physician's orders revealed he had treatment orders in place to receive suprapubic catheter care every shift. The treatment included cleansing the suprapubic site with normal saline solution and covering the site with a drain sponge daily. No other treatment orders were noted to be in effect. On 06/28/2026 at 1:04 P.M. an observation of Resident #12's room noted him treatment supplies in his room on the window sill next to his bed. The treatment supplies included a 437 milliliter bottle of Dakin's solution (a diluted, hospital-grade bleach mixture used as an antiseptic to clean wounds) at 1/4 strength. On 06/30/26 at 9:05 A.M., a follow up observation of Resident #12's room revealed he continued to have treatment supplies sitting on the windowsill next to his bed. Dakin's solution was still on the window sill and he was also noted to have a tube of Clotrimazole Cream 1-0.05% sitting on the same window sill. An interview with the resident at the time of the observation revealed he was not sure why the treatment supplies were left in his room and denied that he had requested them to be there. He suspected they were left in his room for staff convenience. On 06/30/26 at 9:07 A.M., an interview with RN #160 revealed treatment supplies should not be stored in a resident's room and should be kept in the treatment cart when not in use. The nurse was observed to remove the treatment supplies from the resident's room, after she had been made aware. Review of a Minimum Safety Data Sheet (MSDS) for Dakin's Solution Products Wound Clenz revealed it's active ingredient was Sodium Hypochlorite (bleach). A warning label advised not to take internally and it was for external use only. If swallowed, the MSDS advised to get medical help or contact Poison Control Center right away. Review of the MSDS for Clotrimazole revealed the medicated cream was indicated for the topical treatment of candidiasis (fungal infection of the skin). First aid measures for exposure of the eyes included immediately flushing the eyes with plenty of water for at least 15 minutes. For ingestion, it was suggested to not induce vomiting unless directed to do so by medical personnel. If large quantities of that material were swallowed, it was advised to call a physician immediately. 4. Review of Resident #65's medical record revealed an admission date of 03/24/2026. Diagnoses included fractures of lumbar/thoracic vertebrae, Type II Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), asthma, hypertension, and hyperlipidemia. Review of (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the wound provider note dated 06/23/2026 revealed the resident was evaluated for a diabetic ulcer to the right lateral foot. The note documented the resident was cooperative and consented to care, was alert and oriented, comfortable, and in no acute distress. The wound status was documented as improved/healing. The note indicated the orders for treatment were Dakin's solution cleanser, collagen as the primary dressing, ABD pad and wrap with Kerlix as the secondary dressing, and daily and PRN frequency. Observation on 06/28/26 at 10:32 A.M. revealed wound treatment supplies/medications were sitting out on the nightstand in Resident #65's room. The supplies/medications included Dakin's Solution 0.125% / 1/4 strength, Triad Hydrophilic Wound Dressing Paste, and Nystatin Cream 100,000 units/gm. The supplies/medications were accessible in the resident room at the time of the observation. Review of Resident #65's physician orders revealed Dakin's Solution was ordered to be applied to the right foot topically every night shift for wound treatment. Triad Hydrophilic Wound Dressing Paste was ordered to be applied to the buttocks topically every shift for skin breakdown. Nystatin Cream was ordered to be applied to the buttocks and right axilla topically every shift for excoriation. Review of the product labeling for Dakin's Solution, Triad Hydrophilic Wound Dressing Paste, and Nystatin Cream revealed the products stated to keep out of reach of children. During the observation on 06/28/26 at 10:32 A.M., Certified Nurse Aide (CNA) #553 and CNA #153 acknowledged the wound treatment supplies/medications were sitting out in Resident #65's room and were available for easy access. CNA #153 confirmed this was a concern due to multiple residents residing on the secured behavioral unit who were independently ambulatory and had cognitive impairment. CNA #153 removed the wound treatment supplies/medications from Resident #65's room and took them to the nurse to be secured. Review of the facility's policy on Medication Storage reviewed May 2025 revealed the facility should store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff should be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The facility should not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs should be returned to the dispensing pharmacy or destroyed. Medications must be stored in temperature in accordance with manufacturer's specifications.		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on resident interviews, staff interviews, review of mealtimes, and review of dietary schedules, the facility failed to ensure evening meals were served at normal times due to adequate and qualified staff. This had the potential to affect all 21 residents residing on the back East Hall. The facility census was 79. Findings include: Interview on 06/28/26 at 9:30 A.M. with Resident # 42 revealed meals are never served on time and on 06/26/26 dinner was not served until 9:00 P.M. Interview on 06/28/26 at 10 :00 A.M. with Resident # 35 revealed meals have been late for two weeks. Interview on 06/29/26 at 2:30 P.M. with Dietary Aide # 451 revealed she had only employed at the facility since last week and on 06/26/26 Dietary Manager #551 had to stay over to help until 8:00 P.M. Interview on 06/29/26 at 2:43 P.M. with Dietary Manager #551 verified on 06/26/26 the evening dinner trays did not get delivered until 7:00 P.M. and it was outside the normal meal timeframe. She stated there was no reason why specifically just running behind, she was working with two new employees who just started that week. Review of the dietary staffing sheet dated 06/26/26 revealed the Dietary Manager #551 was scheduled 6:00 A.M. to 2:00 P.M. and from 12:00 P.M. to 7:30 P.M. two employees were scheduled; Dietary Aide #451 and Dietary Aide # 651. Review of the facility document titled Meal Times undated, revealed the facility served breakfast between 7:00 A.M. and 8:20 A.M., lunch between 11:00 A.M. and 12:20 P.M., and dinner between 4:30 P.M. and 5:50 P.M.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to notify the state long term care ombudsman of the transfer and/or discharge of two residents. This affected two residents (#81 and #83) of four sampled for discharges/ hospitalizations. The facility census was 79. Findings include: 1. Review of Resident #81's medical record revealed an admission date of 03/28/26, a discharge date of 04/20/26 and diagnoses including encounter for other orthopedic aftercare, acquired absence of right leg above knee, unspecified asthma, diabetes, end stage renal disease, anxiety, acute on chronic diastolic (congestive) heart failure, histoplasmosis, hypertension, and major depressive disorder. Review of Resident #81's admission Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of 15, indicating the resident was cognitively intact. Further review of Resident #81's MDS revealed the resident utilized a wheelchair for mobility, was independent with bed mobility, and required partial/moderate assist with toileting hygiene, transfers and bathing. Review of Resident #81's progress note written by Registered Nurse (RN) #557 on 04/17/26 at 2:18 P.M. revealed the resident was experiencing more pain than normal to the surgical site in her left stump and was needing more assistance than her baseline from staff for her activities of daily living. Review of progress note written by RN#557 on 04/17/26 at 2:22 P.M. revealed the resident's physician wanted the resident directly admitted to the hospital. Review of progress note written by RN #557 on 04/17/26 at 2:56 P.M. revealed the resident had left the facility. In an interview on 06/29/26 at 8:40 A.M. Social Worker Designee (SWD) #466 verified she did not notify the state long term care ombudsman of Resident #81's transfer to the hospital. 2. Review of Resident #83's medical record revealed an admission date of 04/09/26, a discharge date of 04/11/26 and diagnoses including chronic obstructive pulmonary disease, respiratory syncytial virus, chronic respiratory failure, diabetes, paroxysmal atrial fibrillation, heart failure, non-ST elevation myocardial infarction, and peripheral vascular disease. Review of Resident #83's five day MDS dated [DATE] revealed a brief interview for mental status score of six indicating the resident had severe cognitive impairment. Further review of the MDS revealed the resident utilized a wheelchair for mobility, required partial/moderate assistance for transfers and substantial assistance for toileting hygiene. Review of Resident #83's progress notes revealed a note written by Licensed Practical Nurse #456 on 04/11/26 at 3:25 P.M. that indicated the resident's spouse was at the facility to pick up the resident. The resident's spouse was offered education on encouraging the resident to remain in the facility until Monday so the facility could help set up discharge services. Resident and spouse decline and sign AMA forms (against medical advice). Resident #83 and spouse left at this time. In an interview on 06/29/26 at 8:40 A.M. Social Worker Designee (SWD) #466 verified she did not notify the state long term care ombudsman of Resident #83's discharge.		

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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 record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were coded accurately to include all known diagnoses and medication classifications received during the assessment reference date. This affected one (Resident #1) of 24 residents reviewed for MDS assessments. Findings include: Review of Resident #1's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included major depressive disorder, rheumatoid arthritis, polyneuropathy, and chronic pain syndrome. Review of Resident #1's active physician's orders revealed the resident was receiving Atorvastatin (a cholesterol lowering medication) 40 milligrams (mg) by mouth (po) every night at bedtime (hs) for hyperlipidemia. The order originated on 04/08/26. The resident also had an order to receive Citalopram (an antidepressant) 40 mg po every morning for depression. That order also originated on 04/08/26. The resident was also receiving Suboxone (a medication used to treat opioid use disorder by reducing cravings and withdrawal symptoms; it was a combination of a partial opioid agonist that satisfied cravings and an opioid antagonist meant to prevent misuse) sublingual (under the tongue) film 8-2 mg three times a day for chronic pain. That order had been in place since 04/08/26. Review of Resident #1's admission MDS assessment dated [DATE] revealed the resident was not coded as having the diagnosis of hyperlipidemia, despite the resident receiving Atorvastatin every hs for hyperlipidemia. The resident was also not indicated to have the diagnosis of depression, despite having the diagnosis of major depressive disorder, and receiving Celexa 40 mg every morning for depression. Section (N.) that documented classifications of medications the resident received during the seven day assessment period revealed the resident was indicated to have received an antidepressant. She was not coded on the MDS assessment as having received an opioid medication, despite receiving Suboxone three times a day for chronic pain. On 06/29/26 at 4:10 P.M., an interview with RN #650 revealed she was the facility's nurse that completed the MDS assessment for reimbursement purposes. She confirmed Resident #1's admission MDS assessment dated [DATE] was not coded accurately, as it did not include the diagnoses of depression and hyperlipidemia, when she was receiving medications to treat both conditions. She stated she must have overlooked the fact that the resident was receiving medication to treat both diagnoses and she should have added the diagnoses to the diagnoses list. She further acknowledged the resident should have been coded as receiving an opioid, since the resident had been on Suboxone at the time the MDS assessment was completed. She did not code the resident as receiving an opioid due to the drug information they used did not identify it as such. She acknowledged that Suboxone included Buprenorphine, which was a partial opioid agonist (a substance like a drug that binds to a cell receptor and triggered an active biological response).		

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NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Cedar Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure one resident (# 11) had a care plan that included appropriate interventions to prevent her from causing skin impairment when picking at her skin. The facility also failed to ensure a resident had a comprehensive care plan that addressed vision impairment with the use of glasses for one resident, (# 17). This affected two (Resident #11 and #17) of 24 residents reviewed for care plans. The facility census was 79. Findings include:1.) Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included adult-onset diabetes mellitus, obsessive-compulsive disorder (OCD), allergic dermatitis, anxiety disorder, and Schizo-affective disorder. Review of Resident #11's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and she was cognitively intact. She was not known to display any behaviors or reject care during her seven day assessment reference period (03/25/26- 03/31/26). She was dependent on staff for personal hygiene and transfers. Review of Resident #11's physician's orders revealed the resident had orders in place to receive Benadryl (an antihistamine) 25 milligrams (mg) by mouth (po) every 24 hours as needed for itching. She was also receiving Hydroxyzine (an antihistamine) 50 mg po every eight hours as needed for itching. The Benadryl was ordered on 06/09/26 and the Hydroxyzine was added on 06/28/26. Review of Resident #11's active care plans revealed she was at risk for impaired skin integrity related to requiring staff assistance with her activities of daily living (ADL's) and picking at her skin related to her diagnosis of OCD and dermatitis. The goals included no picking at her skin. The interventions did not include the need to assist the resident with trimming her fingernails to prevent her from causing an impaired skin integrity due to picking at her skin. On 06/28/26 at 4:23 P.M., observations of Resident #11 noted her to be lying in bed. She was noted to have multiple scabbed areas of skin to the left side of her head and her bilateral arms. Her fingernails were noted to be long and in need of being trimmed. An interview with the resident at the time of the observation revealed she generally liked to have her fingernails a little longer but she knew the staff were needing to keep her nails trimmed due to her having a history of picking at her skin. She reported she would be fine with the staff trimming them for her. On 06/29/2026 1:49 P.M., a follow up observation of Resident #11 noted her to be in bed watching TV. Her fingernails remained long and in need of being trimmed. Her head had been shaved to a short length and she was noted to be rubbing her head. She continued to have scabbed areas on her scalp where she had been picking at her skin. The resident reported she did not sleep well last night due to itching, but denied any itching at present. On 06/30/26 at 9:48 A.M., an interview with Resident #11 revealed her itching had improved but continued to be an issue for her. She stated the night before last she was not able to get any sleep due to itching and last night she only slept for only about three hours. She was noted to continue to have the scabbed area to the left side of her head. Scratch areas were noted to the left side of her face near her chin and along her jaw line. She had multiple scabbed areas and scratches on her bilateral upper extremities. The resident's fingernails remained long on some of her fingers that extended about an inch past the end of her digits. The resident was again asked if she would be in agreement to allowing the staff to trim her fingernails. She again stated she knew she was supposed to keep them trimmed to prevent from scratching herself and would be okay with staff trimming them. She then commented she would like that if they did. On 06/30/26 at 10:01 A.M., an interview with Registered Nurse (RN) #160 revealed Resident #11 was considered a total (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assist with personal care. She reported the resident was under hospice care and the hospice aide was there two times a week to do her bed baths. She was asked if she was aware of the resident having any skin issues. She reported the resident had been scratching and that was the only skin issue she was aware of. They had the resident on a Medrol (steroid) dose pack and she was receiving Hydroxyzine and Benadryl on an as needed (prn) basis. She was not sure why the resident was itching. She stated last week the resident had them shave her head and then she started digging at her scalp. She confirmed the resident had scabbed areas from picking at her skin. They were applying lotion to her arms but she was not sure if it was Lac-Hydrin lotion or Hydrocortisone cream. A week and a half ago, the resident was told she needed to have her nails trimmed. She claimed the resident allowed them to do some, but not all of them. She described the resident's fingernails as being long, long then, and also dirty underneath. She denied she had documented anything in the resident's medical record about her being encouraged to allow staff to trim her fingernails and refusing to allow them to do so. She was informed the surveyor had talked with the resident twice in the past three days (last time being earlier that morning) and both times the resident verbalized she would like the staff to trim her fingernails. The nurse indicated, if the resident was a diabetic, the nurses would have to trim the resident's fingernails. She confirmed the resident was a diabetic and in need of her fingernails to be trimmed. She was asked to assist the resident with trimming her nails and let the surveyor know if the resident refused. She was not sure why the resident's care plans did not include the need for staff to assist the resident with nail care. She stated she did not have anything to do with the care plans. On 06/30/26 at 10:33 A.M., a follow up interview with RN #160 revealed she did approach Resident #11 about assisting her with nail care and the resident allowed her to do so. The resident told her she would like to have her nails trimmed once a week moving forward. 2.) Review of Resident #17's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included Bipolar disorder, depression, and anxiety disorder. She did not have any diagnoses specific to cognitive impairment such as dementia or Alzheimer's disease. Review of an optometry visit note for Resident #17 dated 03/13/26 revealed the resident was seen on that date as an established patient. She had an Electroretinography (ERG) performed that measured the electrical activity of the retina's light-sensing cells (rods and cones). The resident was indicated to have non-exudative age-related macular degeneration bilaterally in the early dry stage. She was also indicated to have hypertensive retinopathy bilaterally. An invoice indicated the resident had been previously provided with prescription glasses on 03/06/26, prior to the optometrist's visit. Review of Resident #17's quarterly MDS assessment dated [DATE] revealed the resident did not have any hearing, speech, or communication issues. She was coded on the MDS assessment as having impaired vision and had the use of corrective lenses. She was cognitively intact and was not indicated to have displayed any behaviors during the assessment reference period. Review of Resident #17's active care plans revealed she did not have a care plan in place to address her known impaired vision or use of corrective lenses. On 06/28/26 at 1:00 P.M., an observation of Resident #17 noted her to be in bed on a Notepad tablet. She had glasses on and indicated they were reader glasses her son had given her. She reported she had a pair of prescription glasses that came up missing so she was using a pair her son gave her. She confirmed she had impaired vision and was reliant on glasses to be able to read. 06/29/26 at 12:51 P.M., an interview with RN #300 confirmed Resident #11's active care plan did not include a care plan that addressed her vision impairment or use of glasses.		

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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 record review, review of facility policy and interviews, the facility failed to ensure grooming/shaving were provided to dependent residents. This affected one resident (#70) of two residents reviewed for activities of daily living. The census was 79. Findings include: Review of the medical record for Resident #70 revealed an admission date of 03/30/26 with diagnoses including acute diastolic (congestive) heart failure, Type II Diabetes Mellitus without complications, schizoaffective disorder, depression, anxiety disorder, and repeated falls. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15. The resident was assessed to require assistance with all activities of daily living (ADL's). Review of Resident #70's care plan dated 04/14/26 revealed personalized care with interventions including resident prefers to receive a shower. Resident #70 had an ADL self-care performance deficit related to falls, schizophrenia and depression. Interventions included provide assistance with ADL's according to need. Review of the shower schedule provided by the facility revealed Resident #70 shower days are scheduled Tuesdays and Fridays on nightshift. Review of the shower sheets revealed Resident #70 did not receive a shower or facial hair shaved per schedule on 05/29/26, 06/05/26, and 06/19/26. Review of the Certified Nursing Assistant (CNA) Point of Care (POC) documentation revealed no evidence Resident #70 received a shower on 05/29/26, 06/05/26 and 06/19/26. Further review revealed no evidence of shaving being provided since 06/16/26. Interview on 06/28/26 at 1:33 P.M. with Resident #70 and his daughter revealed she has been here visiting for three days, and he has not been shaved. He was someone who always shaved. Resident #70 stated he gets shaved when they give him a shower sometimes. Observation of Resident #70 revealed facial hair. Interview on 06/30/26 at 3:07 P.M. with the Director of Nursing (DON) verified no shower sheets for 05/29/26, 06/05/26 and 06/19/26 for Resident #70 and verified the resident's facial hair had not been shaved. Review of facility policy titled Activities of Daily Living (ADLs), revised 08/2023, revealed the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, demonstrate a resident's ADL's are met to the best of our ability and do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: bathing, dressing, grooming, oral care, nail care, vision/hearing (glasses/hearing aides).		

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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 record review, observation, interview, and policy review, the facility failed to ensure a resident with a known behavior of picking at her skin had her fingernails trimmed as part of her interventions and the facility staff identified areas of impaired skin integrity when completing weekly skin assessments. This affected one (Resident #11) of four residents reviewed for non-pressure skin conditions. They also failed to ensure a resident's hospice provider was notified when an incident occurred involving one of their hospice residents. This affected one (Resident #30) of one residents reviewed for hospice services. Findings include: 1.) Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included adult-onset diabetes mellitus, obsessive-compulsive disorder (OCD), allergic dermatitis, anxiety disorder, and Schizo-affective disorder. Review of Resident #11's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and she was cognitively intact. She was not known to display any behaviors or reject care during her seven day assessment reference period (03/25/26-03/31/26). She was dependent on staff for personal hygiene and transfers. Review of Resident #11's physician's orders revealed the resident had orders in place to receive Benadryl (an antihistamine) 25 milligrams (mg) by mouth (po) every 24 hours as needed for itching. She was also receiving Hydroxyzine (an antihistamine) 50 mg po every eight hours as needed for itching. The Benadryl was ordered on 06/09/26 and the Hydroxyzine was added on 06/28/26. Review of Resident #11's active care plans revealed she was at risk for impaired skin integrity related to requiring staff assistance with her activities of daily living (ADL's) and picking at her skin related to her diagnosis of OCD and dermatitis. The goals included no picking at her skin. The interventions did not include the need to assist the resident with trimming her fingernails to prevent her from causing an impaired skin integrity due to picking at her skin. Review of Resident #11's weekly skin assessments revealed the resident's skin was being checked weekly for any new areas of skin impairment. The staff was to observe the resident's body and document the appearance of her skin, temperature of her skin, skin turgor, and any new alterations in the resident's skin integrity. If no new alterations or changes in the resident's skin integrity, the skin check was complete. The facility staff documented weekly skin assessments being completed between 06/01/26 and 06/29/26, with no new areas of skin impairment indicated to have been present. Review of Resident #11's Hospice Aide Shower Sheets for the past 30 days revealed the resident's last documented bathing activity completed by the hospice aide was on 06/22/26. The hospice aide documented a visual assessment of the resident and did not note any concerns at the time. The shower sheet included a question to indicate if the resident needed her toenails cut, but it did not ask anything about fingernails. There was also no place on the shower sheet to indicate if nail care had been provided during that bathing activity. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/28/26 at 4:23 P.M., observations of Resident #11 noted her to be lying in bed with multiple scabbed areas skin. She had a pea sized scab on the left side of her head and multiple scabs and/ or scratches to her bilateral arms. Her fingernails were noted to be long and in need of being trimmed. An interview with the resident at the time of the observation revealed she generally liked to have her fingernails a little longer but she knew the staff were needing to keep her nails trimmed due to her having a history of picking at her skin. She reported she would be fine with the staff trimming them for her. On 06/29/2026 1:49 P.M., a follow up observation of Resident #11 noted her to be in bed watching TV. Her fingernails remained long and in need of being trimmed. Her head had been shaved to a short length and she was noted to be rubbing her head. She continued to have scabbed areas on her scalp where she had been picking at her skin. The resident reported she did not sleep well last night due to itching, but denied any itching at present. On 06/30/26 at 9:48 A.M., an interview with Resident #11 revealed her itching had improved but continued to be an issue for her. She stated the night before last she was not able to get any sleep due to itching and last night she only slept for only about three hours. She was noted to continue to have the scabbed area to the left side of her head. A scratch mark was noted to the left side of her face near her chin, along her jaw line. She continued to have multiple scabbed areas and scratches on her bilateral upper extremities. The resident's fingernails remained long on some of her fingers that extended about an inch past the end of her digits. The resident was again asked if she would be in agreement to allowing the staff to trim her fingernails. She again stated she knew she was supposed to keep them trimmed to prevent from scratching herself and would be okay with staff trimming them. She then commented she would like that if they did trim them for her. On 06/30/26 at 10:01 A.M., an interview with Registered Nurse (RN) #160 revealed Resident #11 was considered a total assist with personal care. She reported the resident was under hospice care and the hospice aide was there two times a week to do her bed baths. She was asked if she was aware of the resident having any skin issues. She reported the resident had been scratching and that was the only skin issue she was aware of. They had the resident on a Medrol (steroid) dose pack and she was receiving Hydroxyzine and Benadryl on an as needed (prn) basis. She was not sure why the resident was itching. Last week the resident had them shave her head and then she started digging at her scalp. She confirmed the resident had scabbed areas from picking at her skin that were not noted on the weekly skin assessments. They were applying lotion to her arms, but she was not sure if it was Lac-Hydrin lotion or Hydrocortisone cream. She claimed in the past week and a half, the resident was told she needed to have her nails trimmed. She further claimed the resident allowed them to do some, but not all of them. She described the resident's fingernails as being long, long then, and also dirty underneath. She denied she had documented anything in the resident's medical record about her being encouraged to allow staff to trim her fingernails and refusing to allow them to do so. She was informed the surveyor had talked with the resident twice in the past three days (last time being earlier that morning) and both times the resident verbalized she would like the staff to trim her fingernails. The nurse indicated, with the resident being diabetic, the nurses would have to trim the resident's fingernails. She confirmed the resident's fingernails were long and needed to be trimmed. She was asked to assist the resident with trimming her nails and let the surveyor know if the resident refused. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/30/26 at 10:33 A.M., a follow up interview with RN #160 revealed she did approach Resident #11 about assisting her with nail care and the resident allowed her to do so. The resident told her she would like to have her nails trimmed once a week moving forward. 2. Review of Resident #30's medical record revealed an admission date of 03/14/22 and diagnoses including dementia, obstructive and reflex uropathy, anemia, paroxysmal atrial fibrillation, diabetes, acute and chronic respiratory failure, bladder neck obstruction, pleural effusion, chronic diastolic (congestive) heart failure, malignant neoplasm of unspecified part of unspecified bronchus or lung, pulmonary hypertension, hypertension, and osteoarthritis. Review of Resident #30's care plan revealed a hospice care plan initiated on 01/17/25 with an intervention dated 01/17/25 that stated facility will keep hospice staff aware of significant changes in status and coordinate appropriate interventions and follow-up. Review of Resident #30's physician's orders revealed an order dated 10/21/25 to admit to a hospice for diagnosis of adenocarcinoma of lung. Review of Resident #30's progress notes revealed a note written by Licensed Practical Nurse (LPN) #454 on 05/28/26 at 5:45 P.M. stating STNA (Certified Nursing Assistant) answers call light and Res(resident) is observed on the floor in front of recliner. Res(resident) states she was transferring to her chair and went down. No redness, bruising, injuries noted at this time. VS(vital signs)-149/90, 102, 18, 97.8, 98%. Denies pain at this time. Neurological checks initiated. Left grip is greater than right grip per Res(resident)'s usual. PERRL (pupils equal, round and reactive to light). Able to move all extremities. Res(resident) educated to ask for assistance when needed. Notified CNP (Certified Nurse Practitioner), DON (Director of Nursing), and Res(resident)'s daughter of same. Further review of Resident #30's progress notes revealed no indication the hospice provider was notified of the resident's fall. Review of Resident #30's quarterly Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of 15 indicating the resident was cognitively intact. Further review reviewed revealed the resident utilized a wheelchair for mobility, was dependent on facility staff for toileting hygiene, and bathing, required substantial/maximal assistance for bed mobility and transfers and was receiving hospice care. In an interview on 07/01/26 at 9:50 A.M. the Director of Nursing verified there was no documentation the hospice provider was notified of Resident #30's fall on 05/28/26. Review of the policy titled Hospice Policy, dated 05/2025, revealed the facility was responsible for monitoring the resident's status and notifying the primary care provider and the hospice of significant changes in status, new or worsening wounds, falls, signs or symptoms of a new infection or of worsening infection, pain that does not respond to the ordered non-medication and medication interventions, new symptoms or clarification of an order.		

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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. Based on record review, observation, staff interview, and policy review, the facility failed to ensure skin prevention interventions were implemented for a resident with a known pressure ulcer per the plan of care. This affected one resident (#8) of three residents reviewed for pressure ulcers. The facility census was 79. Findings include: Review of Resident #8's medical record revealed an admission date of 05/22/26 with diagnoses including chronic venous hypertension with ulcer of left lower extremity, dysphagia, down syndrome, muscle weakness, retention of urine and chronic kidney disease. Review of Resident #8's quarterly Minimum Data Set (MDS) assessment, dated 06/06/26 revealed severe impaired cognition and he was dependent on staff for bed mobility, transfers with two staff assist, no impairment to upper or lower extremities and was at risk for pressure ulcers. Review of Resident #28's physician's orders, dated 05/27/26, revealed an order for Triad Hydrophilic wound dress external paste to buttocks three times a day and a low air loss mattress. Review of the care plan for Resident #8 dated 05/22/26 revealed he was at risk for skin integrity/pressure ulcers related to incontinence and weakness. Interventions included lift sheet on chair/bed for positioning, pressure reduction devices if ordered and turn and reposition as ordered. Further review of Resident #8's care plan dated 05/27/26 revealed he had an actual impairment to skin integrity, on 06/09/26 a stage III pressure ulcer to coccyx/buttocks with interventions including encourage no briefs in bed, low air loss mattress on bed and identify/document potential causative factors and eliminate/resolve where possible. Review of Resident #8's most recent Encore Wound Care progress note dated 06/23/26 revealed a stage III pressure ulcer to bilateral buttocks including coccyx which was present upon admission. Treatment orders included but not limited to patient should be repositioned every two hours (left side/right side/supine) and no incontinent brief while in bed. Observation and interview on 06/29/26 at 4:46 P.M. of wound care on Resident #8 with Registered Nurse (RN) Unit Manager #154 Licensed Practical Nurse (LPN) #256, Certified Nursing Assistant (CNA) # 361 and CNA #362 revealed, resident in bed upon room entry, staff stated he had a doctor's appointment this morning and returned to facility around 11:30 A.M. Observation revealed Resident #8 had two sheets, one bed pad and an incontinence brief under him while in bed. Staff stated that was from the squad when they brought him back from the appointment. LPN # 154, CNA #361 and CNA #362 verified resident has not been turned or repositioned since returning from appointment at 11:30 A.M. RN #154 verified the items underneath resident is not appropriate for wound healing. Interview on 06/30/26 at 2:06 P.M. with Encore Wound Care Nurse Practitioner (NP) #369 revealed expectations for pressure ulcer management include turning side to side, every two hours as patients tolerate, residents with air mattresses should not be wearing an incontinence brief in bed and the bare minimum between the resident and bed which should be one piece of linen. Review of the facility's policy titled Wound Management Program, updated February 2024, revealed 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 resident's preferences and medical condition necessitate palliative care as the primary focus.		

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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. Based on record review and interview, the facility failed to ensure residents had appropriate justification for use of medications. This affected one (Resident #70) of six residents reviewed for medication use. Facility census was 79. Review of Resident #70's medical record revealed an admission date of 03/30/26 with diagnoses that included acute diastolic (congestive) heart failure, Type II Diabetes Mellitus without complications, schizoaffective disorder, depression, anxiety and repeated falls. Review of the physician's orders dated 04/15/26 revealed an order for Tagamet (used to treat and prevent heartburn, also used for sexually inappropriate behavior) 200milligrams (mg) Oral Tablet one tablet by mouth two times a day for sexual behaviors. Review of Resident #70's behavior documentation from March 2026 through June 2026 revealed one indicated behavior of public sexual acts on 04/29/26. Review of Resident #70's care plan dated 04/07/26 revealed no indication of sexual behaviors. Interview on 06/30/26 at 4:05 P.M. with the Director of Nursing (DON), verified no documentation of sexual behaviors, no care plan indicating sexual behaviors to support the prescribed Tagamet. The DON stated a Certified Nursing Assistant (CNA) told her about the behaviors.		

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NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Cedar Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 1136 Adair Avenue Zanesville, OH 43701	
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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure laboratory testing for a comprehensive metabolic panel (CMP) and lipid panel were obtained in the month of June 2026, as ordered by the physician. This affected one (Resident #1) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #1's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included atherosclerotic heart disease (ASHD) and heart failure. Review of Resident #1's physician's orders revealed the resident was to receive Atorvastatin (a cholesterol lowering medication) 40 milligrams (mg) by mouth (po) every night at bedtime for hyperlipidemia (high cholesterol in the blood). The order originated on 04/08/26. The resident was also receiving Furosemide (a potassium depleting diuretic) 40 mg po twice a day and Potassium Chloride Extended Release (ER) 20 milliequivalents (meq) po every morning for hypokalemia (low potassium level in the blood). The physician's orders included the need to obtain a CMP (blood test that checked electrolyte levels in the blood to include potassium) every three months in the months of March, June, September, and December. She was also to have a lipid panel (blood test that measured cholesterol level in the blood) drawn every six months during the month of June and December. The lab order for routine monitoring of a CMP and a lipid panel was provided on 05/20/26. Review of Resident #1's laboratory testing results revealed her last CMP was obtained on 04/14/26. There was no evidence in the electronic medical record (EMR) of a CMP having been obtained in June 2026. Her EMR was also absent for any evidence of a lipid panel being obtained in June 2026, after it had been ordered to be checked every six months to include the month of June 2026. On 06/30/26 at 8:15 A.M., an interview with RN #160 revealed the residents' labs were drawn by the local hospital's lab services. The lab technician came every Monday through Friday to draw blood. The lab technician used to be there early in the morning, but was generally there by then (time of interview) She had not seen the lab technician in the building that day. Lab orders were entered into the computer and would be reflected on the treatment administration record (TAR) when due. The night shift nurse would look at the TAR's the night before to see who was due to a lab and would fill out a lab slip for those labs to be obtained. The lab slip would then be left at the nurses' station turned upside down. She reported the lab slips for the day had already been filled out, unless someone got missed. She denied they had any labs due that day for Resident #1. On 06/30/26 at 8:45 A.M., the facility's Director of Nursing (DON) was asked to provide a copy of any labs involving a CMP or a lipid panel that had been obtained from Resident #1. The facility's Assistant Director of Nursing (ADON) returned with a copy of the CMP that was collected on 04/14/26. She denied they had a CMP or a lipid panel that had been obtained in June 2026. She reported the resident had a CMP and a lipid panel drawn that morning. She acknowledged the surveyor had already interviewed RN #160 and it was determined that Resident #1 did not have any labs drawn that morning and did not have a lab slip filled out for her to have those labs completed. She further acknowledged the CMP and lipid panel would have been missed for that month, without the surveyor's intervention.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to clean dishes in a safe and sanitary manner. This affected all 79 residents residing at the facility. Findings include: Observation on 06/29/26 at 10:02 A.M. with Regional Dietary Manager #468 of the dishwasher cycles revealed wash temperature of 160 Fahrenheit (F) and rinse temperature of 150 F. She ran five more cycles and temperatures still did not meet minimum requirements. Review of the dishwasher logs for December 2025 revealed on 12/26/25 the breakfast wash cycle was 138 F. No dishwasher logs for January 2026. Review of the dishwasher logs for February 2026 revealed wash cycles on 02/01/26, 02/02/26, 02/04/26, 02/05/26, 02/07/26, 02/09/26, 02/10/26, 02/12/26, 02/15/26, 02/16/26, 02/17/26, 02/18/26, 02/19/26, 02/21/26, 02/22/26, 02/24/26, 02/26/26 did not meet minimum temperature requirement of 150 F. No dishwasher logs for March 2026. Review of the dishwasher logs for April 2026 revealed wash cycles on 04/22/26 did not meet minimum requirement of 150 F; and rinse cycles on 04/03/26 and 04/22/26 did not meet minimum requirement of 180 F. Review of the dishwasher logs for May 2026 revealed wash cycles on 05/10/26 did not meet minimum requirement of 150 F; and rinse cycles on 05/19/26, 05/20/26 and 05/24/26 did not meet minimum requirement of 180 F. Review of the dishwasher logs for June 2026 revealed wash cycles on 06/15/26, 06/18/26, 06/26/26 and 06/28/26 did not meet minimum requirement of 150 F; and rinse cycles on 06/06/26, 06/07/26, 06/19/26 and 06/26/26 did not meet minimum requirement of 180 F. Interview on 06/29/26 at 10:15 A.M. with Regional Dietary Manager # 468 verified the abnormal dishwasher temperatures. Review of facility policy titled Cul. - Dish Machine Operation Policy reviewed May 2026, revealed temperatures, as required by the manufacturer, are as follows: wash temperatures varies 150-165 degrees Fahrenheit and final rinse varies 180-195 degrees Fahrenheit.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and facility policy review, the facility failed to maintain infection prevention and control practices when staff failed to use proper personal protective equipment while providing care for one resident (#11), with the potential to affect 13 additional residents (#1, #3, #16, #17, #19, #22, #28, #33, #39, #51, #55, #61, and #84) who received care from the same staff; and failed to ensure newly hired staff completed required two-step Mantoux/tuberculosis screening upon hire for two of 13 employee files reviewed, Social Services Director #450 and Nursing Scheduler #366. The facility census was 79. Findings Include:1: Interview with the Human Resources Director #150 was conducted on 07/01/26 from 8:00 A.M. to 8:45 A.M. regarding staffing file review, employee health requirements, and Mantoux/TB screening documentation. Review of employee health screening documentation revealed Social Services Director #450 had a hire date of 11/28/25. Review of the employee file revealed the required two-step Mantoux/TB screening was not completed until 02/10/26. During interview, Human Resources Director #150 confirmed Social Services Director #450 had a hire date of 11/28/25 and the two-step Mantoux/TB screening was not completed until 02/10/26. Human Resources Director #150 confirmed the hire date and Mantoux completion date were accurate. Human Resources Director #150 acknowledged the two-step Mantoux/TB screening was not completed timely and stated this was an issue. 2: Review of employee health screening documentation revealed Nursing Scheduler #366 had a hire date of 01/12/26. Review of the employee file revealed the required two-step Mantoux/TB screening was not completed until 02/10/26. During interview with Human Resources Director #150 on 07/01/26 from 8:00 A.M. to 8:45 A.M., Human Resources Director #150 confirmed Nursing Scheduler #366 had a hire date of 01/12/26 and the two-step Mantoux/TB screening was not completed until 02/10/26. Human Resources Director #150 confirmed the hire date and Mantoux completion date were accurate. Human Resources Director #150 acknowledged the two-step Mantoux/TB screening was not completed timely and stated this was an issue. Review of the facility policy titled Tuberculosis Control Exposure Policy, created 02/2022, revised 02/2022, and reviewed 01/2026, revealed the purpose of the policy was to institute an effective Tuberculosis (TB) control plan that included early detection for residents and staff with appropriate follow-up, isolation where necessary, and treatment of persons with active TB. Review of the policy revealed administrative measures would be taken to reduce the risk of exposure of residents and employees to people with infectious TB. Review of the procedure revealed PPD results of all employees would be maintained in employee medical files. Review of the early detection section (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed all employees at the facility would have an initial two-step Mantoux PPD on hire 3. Review of Resident #11's medical record revealed an admission date of 05/22/19 and diagnoses including morbid obesity, diabetes, chronic respiratory failure with hypoxia, anxiety disorder, schizo-affective disorder, repeated falls and a history of a multidrug-resistant organism (MDRO). Review of Resident #11's quarterly Minimum Data Set (MDS), dated [DATE] revealed the resident had intact cognition. Further review of the MDS revealed the resident had limitations in range of motion to both lower extremities and was dependent on staff for personal hygiene and transfers. Review of Resident #11's physicians orders revealed an order dated 10/06/25 for enhanced barrier precautions (EBP) due to a history of a MDRO. Review of Resident #11's care plan initiated on 10/06/25 revealed a care plan that stated Resident #11 required EBP due to a history of a MDRO. Further review of the care plan revealed the EBP should be used when performing dressing, bathing, showering, transferring, personal hygiene, changing linens, toileting and peri-care. An observation of peri-care on 06/29/26 at 2:15 P.M. revealed care was provided by Certified Nursing Assistant (CNA) #555 and CNA #263 to Resident #11. CNA #555 assisted with positioning the resident and CNA #263 provided care, cleansing resident from front to back and utilizing a different part of the washcloth or a different wash cloth for each area cleansed. Resident #11's skin was rinsed with clear water and a clean wash cloth rinsing from front to back and utilizing a different part of the washcloth or a different wash cloth for each area and then dried using the same technique. Both CNAs completed hand hygiene prior to the procedure and wore gloves during the procedure however Resident #11 was in enhanced barrier precautions and they did not use gowns during the procedure. In an interview on 06/29/26 at 2:20 P.M. CNA #263 stated that Resident #11 did not have a catheter or intravenous access (IV) and the wound she had previously on her head was healed. CNA #263 stated that she thought the nurses had just forgotten to remove the EBP sign from the resident's room and that she did not need to be in EBP since her wound was healed. CNA #263 confirmed she did not wear a gown while caring for Resident #11. In an interview on 06/29/26 at 2:20 P.M. CNA #555 stated that she honestly did not notice the EBP sign until questioned about it by the surveyor but that she did not know of any reason for the resident to be in EBP. CNA #555 confirmed she did not wear a gown while caring for Resident #11. Review of the policy titled Enhanced Barrier Precautions Policy, revised 01/2025, revealed that Center for Disease Control (CDC) studies have shown many nursing home residents are unknowingly colonized with MDRO. The CDC has determined that by using EBP, long term care facilities can reduce the spread of MDROs. further review revealed EBP is used in conjunction with standard precautions and expands the use of personal protective equipment (PPE) to donning gown and gloves during high-contact resident care activities such as when performing dressing, bathing, showering, transferring, personal hygiene, changing linens, toileting and peri-care.		