STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366413	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Bethesda The	2971 Maple 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 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** 43064 Based on observation, interview, medical record review, and review of policies, the facility failed to notify the physician and address a change in Resident #11's ability to chew and swallow and failed to implement compression stockings or unna boot dressings per order for Resident #9. This affected two residents (#9 and #11) of 15 residents reviewed for quality of care and treatment. The facility census was 52. Findings include: 1. Review of Resident #11's medical record revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, pulmonary fibrosis, heart failure, depression, anxiety disorder, hypotension, benign neoplasm of parotid gland, altered mental status, and age-related physical debility. Review of Resident #11's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she was cognitively intact. She had no chewing or swallowing concerns. Review of Resident #11's diet orders from 12/04/24 to 01/06/25 revealed an order for a regular texture diet. Review of Resident #11's plan of care dated 12/29/24 revealed the resident had no concerns related to chewing, swallowing, or dentition. Review of Resident #11's progress note dated 11/04/24 revealed the resident was holding pills in her mouth and not swallowing them. The note indicated Resident #11 also held pills crushed in pudding in her mouth. There was no indication the physician or family was notified. Review of Resident #11's Admission assessment dated [DATE] revealed the resident had no swallowing problems and no dental problems. Review of Resident #11's nutrition assessment dated [DATE] revealed no indication the resident had problems chewing or swallowing. Review of Resident #11's medical record from 11/05/24 to 12/29/24 revealed no further documentation related to Resident #11's difficulty swallowing. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's progress note dated 12/30/24 revealed an unnamed Certified Nursing Assistant (CNA) had reported the resident was coughing and gagging with meals and drinks. The nurse noted the resident spit out the medication into her hand and rubbed them on the side of her face. Resident #11 also tried to hold medications in her mouth and then gagged and coughed. There was no indication the physician or family was notified. Review of Resident #11's progress note dated 12/31/24 revealed the resident was admitted to hospice related to physical debilities, and several of her routine medications and laboratory testing had been discontinued. The resident's daughter was in agreement with this. Review of Resident #11's nutrition assessment dated [DATE] revealed the resident had a recent episode of coughing and gagging with oral intake. There were no recommendations related to this and no indication the dietitian had discussed the concerns with the resident, family, or physician. Review of Resident #11's progress note dated 01/06/25 revealed the resident asked for a pureed diet after breakfast. She reported she could not chew her food well enough to swallow it. She received a puree diet for lunch and ate it well. Review of Resident #11's diet order dated 01/06/25 revealed an order for puree texture per the residents request as she could not chew the food well enough to swallow. Interview on 01/08/25 at 2:00 P.M. with Regional Dietitian #100 revealed the facility's dietitian was unavailable. He reported if he became aware of a resident having swallowing problems he would discuss it with nursing to ensure the proper steps were taken, whether that was downgrading a diet or referring a resident for a speech therapy evaluation. Interview on 01/08/25 at 4:01 P.M. with the Director of Nursing (DON) verified there was no evidence the physician or power of attorney (POA) was notified of Resident #11's swallowing problems on 12/30/24. She additionally verified there was no evidence this issue was followed up on or discussed with the resident. The DON reported she had discussed this concern with the resident today who reported that she only had a problem chewing due to poor dentition and she refused the dentist. Interview on 01/08/25 at 4:10 P.M. with Licensed Practical Nurse (LPN) #144 revealed she worked the morning of 12/31/24 and it had not been communicated to her that Resident #11 had problems swallowing and she had not notified the POA or physician. LPN #144 reported Resident #11 had always had problems chewing so she was sure the POA was aware. Interview on 01/09/25 at 7:51 A.M. and 8:25 A.M. with the DON verified prior to 12/30/24 the only indication Resident #11 had chewing or swallowing problems was the progress note on 11/04/24. The resident was not assessed or care planned to have problems chewing or swallowing. She additionally verified she would expect a nurse to notify appropriate parties of changes in a residents abilities to chew or swallow. The DON verified there was insufficient documentation to show anyone followed up or notified the physician or POA after Resident #11's 11/04/24 and 12/30/24 incident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy 'Notification of Change of Condition' dated 12/17/24, revealed the facility must inform the resident, consult with the physician, and notify the resident's legal representative of an accident involving the resident and has the potential for requiring physician intervention, when there is a significant change in the resident's physical, mental, or psychosocial status, or a need to alter treatment significantly. 32801 2. Review of Resident #9's medical record revealed Record review revealed an admitted [DATE] with diagnoses including venous insufficiency, congestive heart failure, hypotension, dementia, diabetes (type 2), retention of urine, and cardiomyopathy. Resident #9 was hospitalized and readmitted to the facility on [DATE]. Review of Resident #9's peripheral vascular disease plan of care dated 12/06/24 revealed no evidence of compression stockings or unna boot treatments. Review of Resident #9's skin integrity plan of care dated 12/06/24 revealed treatments and preventative treatments were to be applied when ordered. Review of Resident #9's orders dated 12/09/24 and 12/27/24 (re-admission) revealed orders for compression socks to be applied in the morning and removed at night. Review of Resident #9's hospital discharge records dated 12/27/24 revealed orders for unna-flex elastic unna boot (compression gauze bandage impregnated with thick creamy mixture of zinc oxide and calamine used to treatment of venous insufficiencies of the leg and venous status ulcers) to be apply topically daily for three days and knee-high anti-embolism (compression) stockings with 20-30 millimeter of mercury (mm Hg) of compression to be worn daily. Review of Resident #9's orders dated 12/28/24 for the unna boot dressing application revealed to apply a unna boot daily for three days to right pretibial (shin area of the leg) area. Special instructions included to change as needed if the dressing becomes dislodged or soiled. On 12/30/24, the orders were changed to cleanse right lower extremity with normal saline or wound cleanser, apply an unna boot, and cover with kling wrap and tubigrip three times a week and as needed. On 12/31/24, the order was changed again to cleanse the wound with wound cleanser or normal saline, pat dry, apply unna wrap to right lower leg and cover with gauze wrap daily and as needed until healed. Review of Resident #9's progress note dated 12/31/24 revealed the resident had a peripheral vascular wound that was present on admission that measured 0.7 centimeters (cm) length by 1.8 cm width, by 0.1cm depth. The right lower leg was red/purple which was indicative of severe peripheral vascular disease (PVD). The listed treatment included cleansing the area with wound cleanser/normal saline. Apply unna wrap daily and cover with gauze wrap. The physician was recorded as being in agreement with the wound treatment, and the resident was informed of treatment orders and reported he would inform his spouse. Nursing would treat, monitor areas and notify the physician if the resident's condition worsened. Review of Resident #9's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for December 2024 revealed no evidence the unna boot was applied from 12/27/24 to 12/30/24 per orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #9 on 01/06/25 at 11:20 A.M., revealed the resident didn't have compression stocking or unna boot in-place. The resident had reported staff had been putting the compression hose/stocking on, but he didn't know where they went. Two surveyors looked around the room and was not able to locate the compression stockings. The resident had a piece of gauze wrapped around a small area below his knee, however most of his lower right leg was exposed. Both lower extremities were red and swollen. A subsequent observation on 01/08/25 at 8:02 A.M. revealed the resident was sitting up in his recliner. The resident did not have compression hose/stocking or an unna boot dressing in-place. The resident reported he still had not found his compression hose/stocking. The resident's lower extremities remained red and swollen. The resident has a gauze dressing in-tact to a small area below the right knee. Interview and observation of Resident #9 on 01/08/25 at 8:10 A.M., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed the resident did not have compression hose/stocking or the unna boot in-place to the right lower leg per his current orders. The ADON removed the gauze dressing and there was an open area noted on the right lower leg below the knee. Interview on 01/09/25 at 7:47 A.M., with the DON and ADON confirmed the resident was ordered compression hose on 12/09/24 and the compression hose were re-ordered upon the resident's re-admission on 12/27/24. The DON confirmed the resident was ordered unna boots daily for three days when he returned from the hospital on 12/27/24, however the order was entered in the computer but for some reason did not transfer over the medication or treatment record. The DON confirmed there was no evidence the unna boot treatments were completed from 12/28/24 to 12/30/24. The DON reported she had started education with staff on how to correctly apply unna boots. Review of facility policy titled General Wound and Skin Care dated 05/10/17 and revised 12/17/24 revealed the facility provides measures that will promote and maintain good skin integrity.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and medical record review, the facility failed to ensure an order was in place and care was documented for Resident #154 who had a catheter. This affected one resident (#154) of two residents reviewed for catheters. The facility identified four residents with indwelling urinary catheters. The facility census was 52. Findings include: Review of Resident #154's medical record revealed an admitted [DATE] with diagnoses including cerebral infarction due to embolism of cerebellar arteries, dysphagia, adult failure to thrive, severe protein-calorie malnutrition, depression, and gastro-esophageal reflux disease. Review of Resident #154's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had moderately impaired cognition. Review of Resident #154's progress note dated 12/24/24 at 4:45 A.M. revealed the resident's abdomen was distended and a bladder scan showed urine present. He was unable to be straight cathed and he was sent to the emergency room to have a urinary catheter placed. Review of Resident #154's progress note dated 12/24/24 at 3:20 P.M. revealed the resident returned from the hospital with a new foley (indwelling urinary) catheter in place. Review of Resident #154's plan of care and physician orders on 01/07/25 at 8:30 A.M. revealed there was nothing related to a urinary catheter. Resident #154's record revealed no care was documented for Resident #154's catheter. Observation on 01/06/25 at 10:25 A.M. revealed Resident #154 had a urinary catheter in place. Interview on 01/07/25 at 8:32 A.M. with Registered Nurse #109 and and LPN #163 verified Resident #154 had a indwelling urinary catheter in place but had no orders or care plan for the catheter. Resident #154 went to the hospital and came back with the catheter. LPN #163 reported she would check the catheter size and put in the orders.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, pharmacy recommendations, and staff interview, the facility failed to implement pharmacy recommendations in a timely manner for Resident #15. This affected one (Resident #15) out of five residents reviewed for unnecessary medications. The facility census was 52. Findings include: Review of the medical record revealed Resident #15 was admitted on [DATE] with diagnoses that included bipolar II, type 2 diabetes, anxiety disorder, and major depressive disorder. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #15 was cognitively intact. The MDS also revealed Resident #15 received antipsychotic and anticonvulsant medication. A pharmacy recommendation dated 10/10/24 revealed Resident #15 had an order for Estring (vaginal ring that reduces the symptoms of menopause) to be replaced every three months at the doctors office. A recommendation was made to add the month the Estring was to be replaced for better monitoring. The recommendation was marked as accepted. Review of the physician orders and Medication Administration Records (MAR) after the 10/10/24 recommendation revealed the month the Estring was to be replaced had not been added. A pharmacy recommendation dated 11/22/24 revealed Resident #15 was ordered Gabapentin (anticonvulsant and to treat nerve pain). A recommendation was made to consider adding a side effect monitoring order set for anticonvulsant's. On 12/19/24, monitoring for anticonvulsant medication was added to observe Resident #15 closely for significant side effects such as drowsiness, Ataxia, Nystagmus, dizziness, blurred vision, nausea, rash, gum enlargement, and jaundice. A pharmacy recommendation dated 12/30/24 revealed Resident #15 received aripiprazole (antipsychotic) medication. An abnormal involuntary movement (AIMS) assessment should be performed at baseline and at least every 6 months. The last AIMS assessment in the medical record was completed on 05/15/24. The pharmacy recommendation was marked as completed with a note the AIMS assessment was completed in October 2024. Review of the quarterly Observation and Data Collection form dated 10/05/24 revealed Resident #15 was not receiving an antipsychotic medication and the AIMS assessment did not need to be completed. Interview on 01/09/24 at 9:45 A.M. Director of Health Services (DHS) verified the recommendation to add the month Resident #15's Estring was to be replaced was not completed. DHS also verified the side effect monitoring for Gabapentin was not addressed until 27 days after the recommendation had been received. DHS verified the last AIMS assessment had been completed on 05/15/24 and an AIMS assessment for Resident #15 was not completed until 01/09/24 after being made aware pharmacy had made an AIMS assessment recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy Consultant Pharmacist Reports revised 11/18 revealed the medical regimen review (MRR) includes evaluating the residents response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. Recommendations are acted upon and documented by the facility personnel and/or the prescriber. The prescriber accepts and acts upon the suggestion or rejects and provides an explanation for disagreeing. The director of nursing or designated licensed nurse addresses and documents recommendations that do not require a physician intervention. Review of the Guidelines for: Abnormal Involuntary Movement Scale (AIMS) revised 05/22/18 revealed a licensed nurse will complete an AIMS assessment on all residents on antipsychotic medications and/or other medications know to cause tardive dyskinesia. The AIMS assessment will be completed if possible prior to the resident beginning this type of medication, or at the earliest possible time; either after admission, after medications are prescribed, and with dosage changes. The AIMS assessment will be repeated for every resident taking antipsychotic medications every six months or as needed for displaying symptoms of tardive dyskinesia.

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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** 43064 Based on interview and record review the facility failed to monitor pain severity, location, and nonpharmacological interventions for Resident #37 who received as-needed pain medication. This affected one resident (#37) of two residents reviewed for pain management. The facility census was 52. Findings include: Review of Resident #37's medical record revealed an admitted [DATE] with diagnoses including unspecified dementia, chronic obstructive pulmonary disease, anxiety disorder, esophageal obstruction, depression, anxiety, dysphagia,and mixed receptive expressive language disorder. Review of Resident #37's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. Review of Resident #37's plan of care dated 11/13/24 revealed she was at risk for pain related to diagnoses and impaired mobility. Interventions included observing and recording verbal and nonverbal signs of pain, notifying the physician of increased pain, administering medications as ordered, and attempting non-pharmacological interventions. Review of Resident #37's physician order dated 12/19/24 revealed an order for Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 milligrams (mg) every four hours as needed. Review of Resident #37's Medication Administration Record (MAR) from 12/19/24 to 01/06/25 revealed as-needed Hydrocodone was administered on 12/21/24 at 9:56 A.M. and 2:26 P.M., on 12/22/24 at 9:10 A. M. and 1:16 P.M., on 12/23/24 at 2:21 A.M. and 10:54 A.M., on 12/24/24 at 10:57 A.M. on 12/25/24 at 8:48 A. M., on 12/26/24 at 5:37 A.M., 9:43 A.M., 3:12 P.M., and 7:33 P.M., on 12/27/24 at 10:14 A.M. and 2:12 P.M., on 12/28/24 at 10:53 A.M., 12/30/24 at 3:42 P.M., and on 01/01/25 at 12:47 P.M. Review of the MAR notes revealed the medication was administered on 12/23/24 for knee pain of six out of 10. There were no additional notes or documentation related to the administration of the as-needed pain medication. There was no further rating of pain, description of pain, or indication of nonpharmacological interventions attempted. Review of Resident #37's progress notes from 12/19/24 to 01/06/25 revealed no further documentation related to the resident's reports of pain or the as-needed administration of Hydrocodone on the above days. Interview on 01/09/25 at 8:25 A.M. with the Director of Nursing (DON) verified there was no documentation of pain level, description of pain, or nonpharmacological interventions. Review of the policy 'Guidelines for pain observation and management' dated 12/17/24, revealed each resident's pain including its origin, location, severity, alleviating and exacerbating factors, current treatment and response to treatment will be observed and documented according to the needs of each individual.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32801 Based on review of the infection control logs, review Center of Disease Control and Prevention (CDC) guidelines, observation, interview, and policy review, the facility failed to ensure policy and procedures were in place for laundering isolation linens and clothing and failed to ensure staff were knowledgeable on the process to prevent infection transmission throughout the facility. This had the potential to affect all 52 resident residing in the facility. Findings include: Review of the infection control log dated 11/2024 to 01/09/24 revealed in November 2024 there were three cases of Clostridium difficile (C-diff, a highly contagious bacterium that causes diarrhea and colitis). In December 2024 there were four cases of C-diff, and in January 2025 (through 01/09/25) there was one case of C-diff recorded. Observation and interview on 01/08/24 at 11:30 A.M., with the Director of Environmental Service (DES) #149 revealed if a resident had C-diff infection, the floor staff would take the laundry from the resident's room to the soiled linen rooms on the hallway. The facility treats all laundry items as contaminated, so the staff don't label or place contaminated linens in any special bag or container. The laundry staff would then go to the soiled linen rooms with a barrel to collect the laundry to transport to the laundry room. The laundry staff would enter on the dirty side of the laundry room and apply gloves, gowns, and goggles and proceed to sort all the laundry. The staff do not separate the contaminated (C-diff) laundry from the non-contaminated laundry due to the facility washing machine being a high-temperature machine. DES #149 reported the hot water temperatures for the washer range from 140-145 and to her understanding the hot water would kill all organisms, including C-diff. DES #149 reported staff would use the wash cycle that was on a chart on the wall to wash the linens or clothing. DES #149 referenced the chart and stated #1 was a pre-set cycle for sheets, #2 was a pre-set cycle for towels, #3 was a pre-set cycle for incontinence pads, #4 was a pre-set cycle for residents' personal clothing items which did not contain bleach, and #5 was a pre-set cycle for blankets or bed sheets. DES #149 confirmed there was an isolation cycle, however it was not used as the hot water temperatures were effective and the isolation cycle contained bleach which would ruin colored items. DES #149 did not know what products or formula was used in which cycle and would have to call the supply company. Interview on 01/09/25 at 9:20 A.M., and 10:36 AM with DES #149 revealed the supply company came out last night to determine what products were used in each cycle. Cycle #1 was for sheets and contained 3.5 ounces of bleach, Cycle #2 was for towels and had 3.5 ounces of bleach. Cycle #3 was for incontinence pads and had 4.5 ounces of bleach. Cycle #4 was for personal items and had no bleach. Cycle #5 was for blankets/bedspreads and had no bleach. Cycle #11 was for isolation and had 4.5 ounces of bleach. DES #149 confirmed resident personal items, including residents infected with C-diff's personal items, would be washed in Cycle #4 with the formula which did not contain bleach. DES #149 confirmed the facility did not have a policy on washing isolation linen or clothing, however she was going to reach out to her corporate office. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/09/25 at 10:53 A.M., with DES #149 revealed the only thing she could find regarding the laundry procedure dated 06/14/12 indicated infection linen would be double bag with two can liners. The procedure called for staff to bring the can liners to the central soiled utility room and place in a tub. The procedure recommended to wash personal laundry at the campus for infection control and not allow residents to take clothing or linens home to wash. Interview on 01/09/25 at 2:49 P.M., with Supplier #500 confirmed he had visited the facility last night to ensure which products were used in each formula/cycle. Supplier #500 reported destainer was the bleach, and if used would kill most of the common organisms. The supplier confirmed personal item cycle, and the blankets/bedspread formula/cycles do not contain bleach (destainer). Review of the facility policy Infection Prevention and Control Program (IPCP) revised 11/15/21 revealed the infection prevention and control program was designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy stated a member of the clinical team shall be designated to monitor the campus IPCP program to perform surveillance to identify, investigate, control, and prevent the spread of infection and reporting for the IPCP. The policy included responsibilities which included to review each department's policies and procedures annually for their adherence to infection control principles. The policy stated this included nursing, dietary, housekeeping, laundry, maintenance, and others as required. The policy additionally listed for a review of in-use disinfectants when evidence of continuing transmission of an infectious agent (such as rotavirus, C. diff, norovirus, etc) are reviewed and changed to a more effective disinfectant as indicated. Review of the CDC Guide to Preventing Clostridium difficile Infections dated 12/18/24 revealed although many EPA registered germicides kill the vegetative C. difficile, only chlorine-based disinfectants and high concentration hydrogen peroxide formulations kill spores. According to the CDC, the risk of disease transmission from soiled linen is negligible, and common-sense hygienic practices for processing and storage of linen are recommended. Policies and procedures should be in place to ensure that soiled linen is handled as little as possible to prevent microbial contamination of the air and of persons handling the linen. Soiled linen should be bagged or placed in containers at the location where it was used and should not be sorted or rinsed at that location. Heavily soiled or contaminated linen should be placed into containers that will prevent leakage. Soiled linen is usually sorted in the laundry before washing. Policies and procedures for appropriate protective apparel to be worn by laundry personnel should be in place and enforced at the laundering facility. The soiled textiles area must be functionally separated from the clean textiles processing area. Functional separation may be obtained by any one or more of the following methods: a physical barrier, negative air pressure in the soiled textiles area, and/or positive air flow from the clean textiles area through the soiled textiles area with venting directly to the outside. To remove significant quantities of microorganisms from grossly contaminated linen commercial laundry facilities, use water temperatures of at least 160 F, and may use 50 to 150 parts per million (ppm) of chlorine bleach as well. Satisfactory reduction of microbial contamination can be achieved at water temperatures lower than 160 degrees Fahrenheit (F) if chemicals suitable for low temperature washing are used. The facility was not able to provide evidence the hot water temperature in the facility's washing machine was greater than 160 degrees F by the conclusion of the survey on 01/09/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366413	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Bethesda The	2971 Maple 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 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** 51074 Based on medical record review, staff interview, and review of facility policy, the facility failed to have justification for prophylactic antibiotics for Resident #38. This affected one resident (#38) of two residents reviewed for antibiotic stewardship. The facility census was 52. Findings included: Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included sepsis, acute cystitis with hematuria, polyneuropathy, and history of prostate cancer. Review of the physicians' orders dated 07/15/24 for Resident #38 revealed orders from a urologist for levofloxacin (an antibiotic) 500 milligrams (mg) by mouth daily for three days, prophylactic due to cystoscopy. On 07/15/24, macrobid (an antibiotic) 100 mg by mouth once daily was ordered prophylactic starting on 07/18/24, continuously for a year's duration. Review of the Plan of Care dated 08/22/24 revealed Resident #38 received long-term prophylactic antibiotic medication related to recurrent urinary tract infections. A listed goal included the resident will not exhibit signs of complications associated with prophylactic antibiotic use. Listed interventions included to encourage fluid intake, observe for signs and symptoms of adverse effects/complications associated with prophylactic antibiotic use and report to medical doctor (MD), observe for sign and symptoms antimicrobial resistant organisms and report to MD, and to obtain labs as/when ordered, reporting results to MD. Interview on 01/09/25 at 11:54 A.M. with Director of Health Service (DHS) and Infection Control Nurse #165 revealed that Resident #38's levofloxacin and macrobid did not meet the criteria for antibiotic use, and there is not a statement by the physician justifying the use of the prophylactic antibiotic and did not meet McGeer criteria for antibiotic use. Review of the policy Infection Prevention and Control Program (IPCP) revised 11/15/21 revealed the IPCP designee will work with campus pharmacy provider regarding an antibiotic stewardship program and campus Medical Director as needed. Outcome surveillance should be reviewed by the IPCP designee. Documentation shall be reviewed within the resident's Electronic Health Record (EHR) to assist in identify if the infection meets the McGeer Criteria.