STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366429	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Zanesville Inc.	4200 Harrington Drive 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, review of the Self-Reported Incident (SRI), interview with staff, and review of the facility policy the facility failed to prevent the misappropriation of medication for Resident #66 by facility staff. This affected one resident (Resident #66) of three reviewed for medications. The facility census was 96. Findings included: Review of the medical record revealed Resident #66 was admitted to the facility on [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease, cerebral infarction, atrial fibrillation, polymyalgia, bipolar disorder, personality disorder, opioid disorder, generalized anxiety disorder, restless leg syndrome, Crohn's disease, malignant neoplasm of the colon, migraines, and xerosis cutis. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #66 had moderately impaired cognition. Review of the August 2024 physician orders revealed Resident #66 had an order for sumatriptan 100 milligrams as needed for migraines. The original order was from 11/30/23. Review of the SRI date 05/01/24 revealed Staff Coordinator #310, reported an allegation of possible misappropriation of resident medication by a facility nurse. The Administrator was notified and the allegation was reported to the Ohio Department of Health. The alleged perpetrator was immediately suspended and another alleged perpetrator identified through interviews was suspended immediately upon discovery. The alleged victim was interviewed, her documents and records were reviewed with no concerns identified. Resident #66 remained at her baseline. The in-house residents were interviewed with no concerns identified. All staff were educated on Abuse, Neglect and Misappropriation policy. All nurses were required to complete education on how to prevent medication errors and ethics/corporate compliance. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the signed witness statement from Staff Coordinator #310 dated 05/01/24 revealed Registered Nurse (RN) #311 came into her office around 7:30 A.M. regarding another issue. Staff Coordinator #310 asked RN #311 how her headache was from the day before and RN #311 told her she still had it. RN #311 indicted to her she thought about calling off due to the headache but did not want to short the facility a nurse on night shift. RN #311 stated a resident had a medication that helped her and she had a prescription for the same medication so she took one of her pills. RN #311 left her office and clocked out for the day and she notified the Administrator immediately. Review of the typed unsigned statement dated 05/01/24 conducted by the Director of Nursing and Administrator revealed they interviewed RN #311. RN #311 stated she had a headache for the past few days and was unsuccessful in getting it to subside. She stated she came to work on 04/30/24 with a headache and as the night went, she stated it got worse, She stated she tried multiple ways to relieve it. The Administrator asked RN #311 if headaches were common for her and RN #311 stated they used to be but not currently. She stated she could usually get them to go away with Excedrin. The Administrator asked RN #311 if she had a prescription for migraine medication and RN #311 stated she had a prescription for sumatriptan but she did not have any at the moment. RN #311 went on to say she had been overwhelmed and could not get any relief and it was suggested to her that there was Imitrex (sumatriptan) in Unit 2. She stated she did not want to do it but she could not function. RN #311 stated she went over to Unit 2 and asked the nurse working if there was Imitrex she could take and she gave her one and she took it. RN #311 stated it did not occur to her it would be misappropriation because it was not a narcotic. RN #311 clarified the staff member who suggested there was Imitrex on Unit 2 did not state it was a resident's medication and did not state a resident's name. She also clarified the staff member was the nurse she would have relieved on 04/30/24 Licensed Practical Nurse (LPN) #312. She stated she was telling LPN #312 how she had a migraine and was feeling really bad and nothing was working. She verified at this time she knew it was a resident's medication she was taking. She stated the nurse on Unit 2 did not have to look the medication up she just got it out of the medication cart and gave it to her. She stated she thought the nurse was aware she gave her and resident's medication. RN #311 expressed deep remorse for her actions. RN #311 was informed she was suspended pending investigation. Review of the typed unsigned statement dated 05/01/24 conducted by the Director of Nursing and Administrator revealed they interviewed RN #313. RN #313 was informed it was reported RN #311 had come over to Unit 2 the night before and asked for a medication from her medic cart and if she had any recollection of it. RN #313 stated RN #311 had asked her for Imitrex. RN #313 stated she assumed it was for a resident because you needed a prescription for it. She stated RN #311 never really stated who it was for but she never seen her ingest it either. She believed it was for another resident. Review of a letter from the pharmacy dated 05/03/24 revealed the pharmacy replaced the dose of sumatriptan 100 milligrams at no cost to the resident. Review of the Ohio Board of Nursing (OBN) complaint form dated 05/08/24 revealed the facility filed a complaint concerning the incident with the OBN against RN #311. On 08/07/24 at 11:18 A.M. an interview with the Administrator verified RN #311 took medication from Resident #66 and she was terminated for misappropriation. She stated reports were filed with the OBN and police. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation, dated 11/01/16 revealed the facility would not tolerate mistreatment, abuse, neglect. Misappropriation of resident property, or exploitation of its residents. Misappropriation of resident property was the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. This deficiency represents noncompliance as an incidental finding during the investigation of Master Complaint Number OH00156251.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record and interview with the staff the facility failed to ensure a wound vacuum (vac) for Resident #58 was changed as ordered, and medications were administered in a timely manner for Resident #96. This affected one resident (Resident #58) of three reviewed for wounds and one resident (Resident #96) of three reviewed for medications. The facility census was 96. Findings included: 1. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included acute osteomyelitis to the left ankle and foot, left foot fracture, thoracic aortic aneurysm, diabetes, right foot amputation, and Charcot [NAME] Tooth Disease. Review of the Five-Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #58 had intact cognition. Review of the August 2024 physician's order revealed Resident #58 had an order to cleanse the left heel. Apply black foam as primary dressing, apply the wound vac at 125 millimeters of mercury (mmHg) as the outer dressing once a day on Tuesday, Thursday and Saturday from 7:30 A.M. to 7:30 P.M. dated 07/13/24. Review of the August 2024 treatment administration record revealed on 08/01/24 Resident #58's wound vac to his left heel was not change as scheduled. The comment note indicated the previous shift was to complete. Review of the progress notes from 07/31/24 to 08/02/24 revealed no documentation as to why the wound vac of Resident #58 was not completed as ordered on 08/01/24. On 08/05/24 at 2:50 P.M. an interview with Resident #58 revealed this was the second time he had been at the facility. He stated the first time the facility was great, very attentive. He stated this time he cannot get any care. He stated they are supposed to change his wound vacuum on Tuesday, Thursday and Saturday but they did not change it on Thursday. He stated he asked first shift three times to change it and they did not. He stated the day shift nurse told him he would be in later to do it but then he came in and stated he would not have time and he would let the second shift know they needed to do it. He stated the second shift nurse came into give him medication and he asked her if they told her she needed to change his wound vac and she stated they did and she would be back later to completed it but she never did. He stated he was leaving today because he was not staying at the facility another day. On 08/06/24 at 10:16 A.M. an interview with Registered Nurse #305 confirmed on 08/01/24 he did not get the wound vac for Resident #58 changed due to running out of time. He stated he was training a new hire, had two new admissions, and did not anticipate how long it was going to take to complete the dressing change for a different resident, which it took almost an hour to complete. He stated he spoke to Resident #58 and he was okay with second shift changing his wound vacuum. He stated when he came in the next day his wound vacuum still had not been changed so he changed it. He verified he ran out of time 08/01/24 to change it and there was no documentation he had changed it on 08/02/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #96 was admitted to the facility on [DATE]. Diagnoses include fracture of the left femur, heart failure, hypertension, polyneuropathy, chronic pain, osteoporosis, major depressive disorder, hypothyroidism, hyperlipidemia, gout, cognitive communication deficit, and muscle weakness. She was discharged to home on 06/18/24. Review of the Admission MDS 3.0 assessment dated [DATE] revealed Resident #96 had intact cognition and received scheduled pain medications. Review of the daily pain assessments from 05/25/24 to 06/15/24 revealed Resident #97's pain level ranged from zero to eight. Review of the physician's orders revealed Resident #96 had an order for oxycodone-acetaminophen 3/325 milligrams every six hours at 8:00 A.M., 2:00 P.M., 8:00 P.M., and 2:00 A.M. dated 05/25/24. Review of the June 2024 Medication Administration record revealed the oxycodone-acetaminophen 3/325 milligrams (mg) every six hours was administered late on 05/26/24 3:05 P.M. for 2:00 P.M. and on 05/30/24 at 3:27 A.M. for 2:00 A.M. Review of the July 2024 Medication Administration record revealed the oxycodone-acetaminophen 3/325 mg every six hours was administered late on 06/05/24 at 9:57 P.M. for 8:00 P.M., on 06/06/24 at 3:02 A.M. for 2:00 A.M., at 06/07/24 at 12:57 A.M. for 06/06/24 at 8:00 P.M. (almost five hours late), on 06/07/24 at 3:03 A.M. for 2:00 A.M., on 06/07/24 at 9:56 P.M. for 8:00 P.M., on 06/08/24 at 3:23 A.M. for 2:00 A.M., and on 06/15/24 at 3:42 A.M. for 2:00 A.M. On 08/06/24 at 8:45 A.M. an interview with the Director of Nursing confirmed the oxycodone-acetaminophen 3/325 mg for Resident #96 was documented as administered late of several days. This deficiency represents non-compliance investigated under Complaint Number OH00155452 and OH00156251.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 35765 Based on observations, review of the facility meal spreadsheet, interview with staff and review of the facility policy the facility failed to ensure the residents were served the proper portion size of meat. This had potential to affect all residents receiving meals from the kitchen except for nine residents (Resident #1, #5, #14, #51, #61, #80, #81, #86 and #88) the facility had identified as nothing by mouth, mechanical soft or pureed diets. The facility census was 96. Findings included: Review the spreadsheet for 08/05/24 revealed the residents were to receive a three-ounce slice of teriyaki pork. Observation of meal service on 08/05/24 from 11:15 A.M. to 12:00 P.M. revealed the facility was serving precooked teriyaki pork however the sliced pieces for the regular texture diets (diets that were not mechanical soft or pureed) looked smaller than a three ounce portion. Dietary Coordinator #300 weighed a piece of pork and it only weighed 1.5 ounces. She verified at this time the pork was not three ounces. [NAME] #301 checked all the meal trays on the already filled Unit 3 food cart and the pork slices only weighted between one ounce to 2.5 ounces. [NAME] #301 placed more teriyaki pork on the plates. Review of the facility policy titled, Therapeutic Diet Spreadsheet, dated 01/15 revealed a therapeutic diet spreadsheet would be available and followed at all meals. This would be used as a guideline for accurately serving all therapeutic and texture modified diets that havephysician's orders for the same. This deficiency represents non-compliance investigated under Complaint Number OH00154938 and OH00155452.