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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366429 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/20/2024 |
| NAME OF PROVIDER OR SUPPLIER Altercare Zanesville Inc. | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>28704</p> <p>Based on self-reported incident review, fire drill review, policy review and interview, the facility failed to submit a self-reported incident (SRI) for possible neglect after staff were observed sleeping on the night shift. This affected 27 residents (#65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #230) residing on Unit 3. The census was 91.</p> <p>Findings include:</p> <p>Review of the facility Self-Reported Incidents (SRIs) revealed no allegations of abuse, neglect or misappropriation had been reported to the Ohio Department of Health (ODH) since 08/20/24.</p> <p>On 09/19/24 at 5:07 A.M., interview with State tested Nurse Aide (STNA) #203 revealed she was not aware of staff sleeping while at work.</p> <p>On 09/19/24 at 5:09 A.M., interview with Licensed Practical Nurse (LPN) #200 (agency staff) stated she had discovered a STNA sleeping and had handled the situation stating she educated the staff member. The STNA stated she just had her eyes closed so she told the STNA not to close their eyes like that again. LPN #200 stated she did not remember the name of the STNA and did not report this to the nursing supervisor or the Administrator. LPN #200 stated this occurred about a month ago and she was not aware of staff sleeping since that time.</p> <p>On 09/19/24 at 5:29 A.M., interview with STNA #216 stated about a month or two ago she observed STNA #204 sitting in a chair on the night shift with her eyes closed and asleep. STNA #216 informed her nurse of the observation and the nurse also observed STNA #204 sleeping.</p> <p>On 09/19/24 at 7:10 A.M., interview with the Administrator revealed staff were not to be sleeping while on duty. The Administrator stated there had been an incident a few days earlier of staff reportedly sleeping. The Director of Nursing (DON) was notified and she had the nurses check the units and they reported to the DON that no staff were asleep.</p> <p>Review of a Facility Investigation Packet (undated) revealed the following:</p> <p>a. All Staff Meeting (STNAs) dated 09/17/24 included topics of sleeping on a shift.</p> <p>(continued on next page)</p> | | |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: 366429 | Facility ID: 366429 If continuation sheet Page 1 of 5 |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>b. Two electronically written statements (undated) signed by the DON of interviews with LPN #200 and LPN #202 that stated at 1:00 A.M. it was reported that STNA's were sleeping on a unit but when they responded to the hallway, they did not see anyone sleeping.</p> <p>c. Review of the Fire Drill Form dated 09/17/24 at 2:00 A.M. revealed a silent fire drill was conducted. The simulation situation was smoke coming out of an outlet in the hallway on Unit 1. A head count was completed and resident doors were closed. No problems were noted on the Drill Overview.</p> <p>d. Review of the Event Statement Form - QAA Document (09/17/24) revealed Maintenance Assistant #205 was conducting a silent fire drill on 09/17/24 at 2:00 A.M. when he came on the 300 hall, STNA #203, STNA #204 and LPN #201 were asleep on the couch and he had to wake them up to sign the Fire Drill Form. Maintenance Assistant #205 stated there was also a resident still up walking around at the time of the observation. The statement did not indicate the name of the resident.</p> <p>e. There were no written staff statements including LPN #201, STNA #203 or STNA #204 in the packet for review.</p> <p>f. There was no documentation regarding residents residing on Unit 3 for any signs/symptoms of neglect after the discovery of staff sleeping.</p> <p>On 09/19/24 at 8:50 A.M., interview with the DON revealed Maintenance Assistant #205 had called off for today. At 9:05 A.M., a phone call was made to Maintenance Assistant #205; however, there was no answer. At 9:13 A.M., a phone call was made to STNA #204; however, there was no answer.</p> <p>On 09/19/24 at 8:59 A.M., interview with Maintenance Coordinator (MC) #208 revealed Maintenance Assistant #205 was stripping and waxing the floor in the therapy room on the night shift and was asked to complete a silent fire drill. Maintenance Assistant #205 had informed him that he had found staff sleeping at the time of the drill and that it had been reported to the DON.</p> <p>On 09/19/24 at 9:20 A.M., interview with the Administrator stated she interviewed Maintenance Assistant #205 since the incident but had not documented the interview but he stated the same story as in his written statement. He did add that LPN #201 and STNA #203 were asleep on one couch and STNA #204 was asleep on another couch and he had to wake them up to sign the fire drill sheet. The Administrator stated when staff went back to check on the Unit 3 (after Maintenance Assistant #205 observed the above staff sleeping), no staff were observed to be asleep; however, the Administrator did verify they had already been awakened by Maintenance Assistant #205 to sign the training sheet. The Administrator stated she had not filed a Self-Reported Incident (SRI) for the above incident because she felt this was an Employee Conduct concern and did not rise to the level of neglect. The Administrator verified she did not have her investigation completed to date and was unaware of other staff sleeping on the job. The Administrator verified the time of the DON's written statements was an hour prior to staff being found sleeping by Maintenance Assistant #205 and if staff were sleeping, they were not providing the care and services to residents.</p> <p>On 09/19/24 at 10:57 A.M., interview with the Administrator stated Maintenance Assistant #205 did not allege neglect of care or services and the facility had not received any complaints from family regarding neglect; therefore, she did not feel it needed to be reported as a SRI.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of the policy: Abuse, Mistreatment, Neglect, Misappropriation of Resident Property and Exploitation (11/01/26) revealed to investigate all allegations, suspicions and incidents of Abuse, Neglect, Misappropriation of Resident Property and Exploitation, and injuries sustained by its residents. Facility staff should immediately report all such allegations to the Administrator and the ODH in accordance with the procedures in this policy.</p> <p>This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH 00157767.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on observation, medical record review, policy review and interview, the facility failed to maintain infection control practices during incontinence care and failed to ensure staff wore face masks during a COVID-19 outbreak. This affected one resident (#70) of two residents observed for incontinence care and had the potential to affect 31 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30 and #31) residing on Unit 1 during the COVID-19 outbreak. The census was 91.</p> <p>Findings include:</p> <p>1. On 09/19/24 at 4:58 A.M., observation of the facility front entrance door revealed a sign indicating the facility was currently under a COVID-19 Outbreak and masks should be worn. A box of face masks was available to use at the receptionist window.</p> <p>On 09/19/24 at 5:05 A.M., observation of Unit 1 revealed two licensed practical nurses (LPN's) (#200, #202) sitting at the nurses' desk and STNA (#203) walking down the hallway. Licensed Practical Nurse (LPN) #200 and #202 did not have a face mask on or within arms reach, State tested Nurses Aide (STNA) #203 was observed with a face mask looped around her ears; however the mask itself was positioned down around her neck. At the time of the observation, LPN #200, LPN #202 and STNA #203 verified staff were to be wearing face masks due to the current COVID-19 outbreak.</p> <p>On 09/19/24 at 7:10 A.M., interview with the Administrator verified staff should have been wearing face masks due to the current COVID-19 outbreak.</p> <p>2. Medical record review revealed Resident #70 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus and heart failure.</p> <p>Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #70 was frequently incontinent of urine.</p> <p>On 09/19/24 between 5:34 A.M. and 6:02 A.M., observation of Resident #70's incontinence care revealed STNA #215 gathered supplies, washed her hands, and applied gloves. Resident #70's incontinence product was removed, observed to be urine soaked and STNA #215 put the incontinence product on the bare floor without a barrier. STNA #215 cleansed the resident with three disposable incontinence wipes and then placed them on the floor with the soiled incontinence product. STNA #215 placed a clean incontinence product on the resident, covered the resident with a blanket, picked up the soiled incontinence product and wipes off the floor and placed them into a trash bag. STNA #215 left the room with the trash bag, walked the trash to the central bath and removed her gloves.</p> <p>On 09/19/24 at 6:02 A.M., interview with STNA #215 verified she placed the urine soiled incontinence products on the floor without a barrier, did not change her gloves during incontinence care, and did not remove her soiled gloves prior to leaving the resident's room to dispose of the trash.</p> <p>On 09/19/24 at 7:10 A.M., interview with the Administrator verified soiled incontinent products should not be placed directly on the floor without a barrier.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the undated policy: Hand Washing/Hand Hygiene revealed the policy was to ensure proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infection. Hand washing was to occur after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin and the use of gloves does not replace hand washing.</p> <p>This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00157767.</p> <p>This deficiency is evidence of continued non-compliance from the survey completed 09/13/24.</p> | | |