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	10/22/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, family interview, and staff interview, the facility failed to ensure a resident, who was known to have multiple dislodgements of his Percutaneous Endoscopic Gastrostomy (Peg) tube, had an abdominal binder in place as ordered to prevent any accidental dislodgements. This affected one resident (#4) of three residents reviewed for feeding tubes. Findings include: Review of Resident #4's medical record revealed he was admitted to the facility on [DATE] with the diagnoses of a traumatic brain injury due to a fall, cognitive communication deficit, hemiplegia (paralysis) and hemiparesis (weakness) following a stroke affecting the left non-dominant side, dysphagia, and gastrostomy status (surgical placement of a tube through the abdominal wall into the stomach for the purposes of providing nutritional supplements). Review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. He was not noted to have displayed any behaviors, nor was he known to reject care during the seven day assessment period. He had a functional limitation in his range of motion on one side of his upper and lower extremities. He was coded on the MDS as having the use of a feeding tube and received 51% or more of his calories through his feeding tube. Review of Resident #4's active care plans revealed he had a care plan in place for having the use of a tube feeding for the primary source of nutrition due to dysphagia. The interventions included the need for an abdominal binder to be in place related to frequent tube displacements. The intervention had been in place since 09/30/24. Review of Resident #4's progress notes revealed a nurse's note dated 09/26/24 at 1:00 P.M. that indicated the nurse entered the resident's room to administer his afternoon meds. His Peg-tube was noted to be dislodged and was lying on the resident's abdomen with the balloon deflated. The nurse attempted to reinsert a new Peg-tube unsuccessfully. The physician was notified and a new order was obtained to send the resident to the emergency room to replace his Peg-tube. He returned to the facility on [DATE] at 4:31 P. M., after his Peg-tube had been replaced. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's progress notes revealed a nurse's note dated 09/28/24 at 2:35 P.M. that indicated the nurse went into the resident's room to administer medication to resident and flush his Peg-tube. The nurse noticed that the Peg-tube was not secured in place and was found out of placement. The physician was contacted and gave an order to transfer the resident to the emergency room . The resident returned to the facility on [DATE] at 9:00 P.M. with a new Peg-tube placed and an abdominal binder on. Further review of Resident #4's progress note revealed a nurse's note dated 10/13/24 at 6:17 A.M. that indicated the nurse was called into the resident's room by a nursing assistant and was notified that the resident's Peg-tube was not in place and was leaking all over his bed. The nurse assessed the resident's abdomen and noted the Peg-tube to be out of place. The nurse unsuccessfully attempted to place a sterile Foley catheter into the Peg stoma in an effort to maintain patency. A new order was received to send the resident out to the hospital. He did not return to the facility until 10/16/24 at 11:00 A.M. Review of the treatment administration records (TAR's) for October 2024 revealed the nurses were initialing to indicate the abdominal binder was in place every shift. The nurse working 10/13/24, when the Peg-tube was dislodged for the third time, indicated the abdominal binder was in place during the evening shift. On 10/22/24 at 10:08 A.M., an interview with Resident #4's representative revealed the resident has had his Peg-tube dislodged several times while in the facility. She stated they were supposed to use an abdominal binder, but she was told it had been misplaced when the Peg-tube was dislodged for the third time. On 10/22/24 at 1:25 P.M., an interview with Licensed Practical Nurse (LPN) #100 confirmed she was the nurse working the night of 10/13/24, when Resident #4's Peg-tube was dislodged for the third time. She stated, when she attached him to his enteral feeding that night at 8:00 P.M. and when she did most of her flushes through the night, everything was fine. It was not until she went in to do the last flush for the night that she noted it (Peg-tube) was out and the enteral feeding had leaked everywhere. She reported the Peg-tube was completely dislodged at that time and was not in place. She was asked what they did to try to prevent the Peg-tube from being dislodged. She stated they were supposed to have an abdominal binder on the resident, but he did not have one on that night. The abdominal binder was not in place when she started her shift. They could not find the abdominal binder anywhere in his room and she was not aware they had any others in the central supply room that could have been used. She just found out a couple of days ago that there were extra abdominal binders in the central supply room if needed. She reported the abdominal binder was effective when used to prevent an accidental dislodgement. She felt the resident's peg tube likely became dislodged due to him getting it caught under his arm when moving in bed. She did not feel it was intentional on the resident's part to pull it out. This deficiency represents non-compliance investigated under Master Complaint Number OH00158726.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, and staff interview, the facility failed to ensure a resident received the appropriate eating equipment and utensils as ordered during a meal to aid the resident in being able to feed himself. This affected one resident (#4) of three residents observed for eating/ feeding assistance. Findings include: Review of Resident #4's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a traumatic brain injury secondary to a fall, hemiplegia (paralysis) and hemiplegia (weakness) affecting his left non-dominant side, dysphagia, cognitive communication deficit, muscle weakness, and need for assistance with personal care. Review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had unclear speech and was usually able to make himself understood and was usually able to understand others. He had moderately impaired vision without the use of corrective lenses. His cognition was severely impaired and he was not known to display any behaviors or reject care. He had a functional limitation in his range of motion on one side of his upper and lower extremities. Review of Resident #4's active care plans revealed he had a care plan in place for an impaired ability to perform or participate in daily activities of daily living (ADL) care related to a stroke, traumatic brain injury, left hemiparesis, dysphagia, and dysarthria. The goal was for the resident to participate with ADL's as much as possible and for him to be neat in appearance daily. He was also to maintain his current level of ADL's every day, without a decline by the target date. The interventions included the use of built-up foam utensils and a sip cup with handles for all meals. Review of Resident #4's physician's orders revealed he was on a low concentrated sweet diet at a pureed consistency with honey thick liquids. He was to receive a tray from the kitchen for lunch and supper. The orders also specified the use of built-up foam handled utensils and sip cups with handles for all meals. That order originated on 10/17/24. On 10/21/24 at 5:20 P.M., an observation of Resident #4 noted him to be sitting up in bed with his supper tray on the bedside table in front of him. He was served a pureed diet as ordered and had thickened liquids in two separate cups. He drank the liquids, but had not touched his food. He was noted to have regular eating utensils on his tray and not the built-up foam handled utensils as ordered. He was also noted to have been served his thickened liquids in regular cups and not two handled sip cups as ordered. His meal ticket on his tray specified he was to have black foam handled utensils and a two handed sip cup during for his meals. Findings were verified by Licensed Practical Nurse (LPN) #150. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21/24 at 5:26 P.M., an interview with LPN #150 revealed Resident #4 was to be on a pureed diet with honey thickened liquids. He stated the resident received a tube feeding at night that ran from 8:00 PM to 8:00 AM. He was asked how much assistance the resident needed for eating and the nurse replied it was mixed. They encouraged him to do it himself, but the aides would help as needed. He has seen him eat and indicated the resident did have trouble getting food to his mouth and would make a mess. He also indicated the resident was supposed to have the use of heavy thick grip utensils, but stated the resident used regular cups. He was not aware that two handled sip cups were to be used for all his meals. He verified the resident's orders did include the need for built-up utensils and a two handed sip cup with meals. He had known the resident to not have received built-up utensils or a two handed cup at times in the past depending on who was working in the kitchen. He acknowledged the resident's meal ticket clearly specified the resident was to receive built-up utensils and a two handed sip cup for his meals. He further acknowledged the staff member passing the trays should be reviewing the meal ticket when the tray was delivered to ensure the resident received the appropriate diet and eating/ equipment and utensils were provided as needed. This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00158726.