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	12/10/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to maintain care and services for pressure ulcers. This affected one (#38) resident observed for a pressure ulcer dressing change. The facility identified five residents with pressure ulcers. The census was 92. Findings include: Medical record review revealed Resident #38 was admitted on [DATE] with diagnoses including paraplegia and Stage IV (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) pressure ulcer to the left ischium. Review of the Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #38 was cognitively intact for daily decision-making and had a Stage IV pressure ulcer. Review of the care plan: Pressure Injury (revised 10/10/24) revealed to complete treatments as ordered. Review of the electronic Physician Orders dated December 2024 revealed left gluteal cleft cleanse with Dakin's, apply Dakin's soaked kerlix gauze and cover with dressing. The treatment was to be completed daily. (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

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 12/10/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 between 2:53 P.M. and 3:12 P.M. observation of Resident #38's left ischium pressure ulcer dressing change revealed the following: Registered Nurse (RN) #398 entered Resident #38's room with gathered pressure ulcer dressing change supplies. RN #398 prepared a clean field on the overbed table with prepoured Dakin's Solution 0.125%, kerlix, gauze, hand sanitizer and gloves. RN #398 removed a pair of bandage scissors from his scrub top pocket and cleaned the scissors with an alcohol swab. RN #398 used the bandage scissors to cut the kerlix and returned the bandage scissors to his scrub top pocket. Resident #38 was laying in bed and was assisted to his right side to expose the left ischium. The left ischium was not covered with a dressing, wound packing could be observed coming from the wound and a drainage collection bag with yellow urine was observed under the resident. RN #398 verified a dressing was ordered to cover the wound to absorb drainage, protect the wound and the resident should not have been laying on the drainage collection bag. RN #398 looked in the bed and through the linens and no dressing was found. RN #398 removed the packing from the wound and cleaned the wound. RN #398 removed his soiled gloves, used hand sanitizer, and applied new gloves. RN #398 soaked the cut kerlix roll in a cup of Dakin's solution and then packed the wound; however, there was an excess of Dakin's soaked gauze extending from the wound. RN #398 put his gloved hand into his scrub shirt pocket, removed the bandage scissors and used the scissors to cut the kerlix. At the time of the observation Assistant Director of Nursing #404 asked RN #398 if those were clean and he stated yes. RN #398 did not removed his gloves/hand wash after putting his gloved hand in his scrub shirt pocket to obtain the bandage scissors. RN #398 covered the wound with a dermaright dressing, assisted the resident in bed, moved the table next to the bed and gathered supplies with the same gloved hands. On 12/09/24 at 3:12 P.M., interview with RN #398 verified the above. On 12/09/24 at 3:25 P.M., interview with RN #400 verified RN #398 informed her no dressing was covering the wound and no dressing was found in the resident's bed. RN #400 verified nurse's bandage scissors were contaminated once he put them in his scrubs pocket and should have been cleaned prior to use. Review of the undated policy: Wound Care revealed the facility policy was to provide guidelines for the care of wounds to promote healing. Procedure included establishing a clean field and placing all items to be used during the procedure on the clean field, position the resident, cleanse hands, put on exam gloves, remove old dressing, discard old dressing, wash hands, put on gloves, cleanse wound per orders. wash hands, apply gloves, apply dressing per order, discard disposable items, and wash hands. This deficiency represents non-compliance investigated under Complaint Number OH00160319.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review, manufacturer guideline review and interview, the facility failed to administer medications as ordered. This affected three (#30, #64 and #270) of three residents observed for medication administration with five errors out of 33 opportunities resulting in an error rate of 15.15%. The census was 92. Findings include: 1. Medical record review revealed Resident #30 was admitted with diagnoses including glaucoma, chronic iridocyclitis left eye, and dry eye syndrome of bilateral lacrimal glands. Review of the careplan: Visual Function (revised 11/22/24) revealed impaired vision related to hypertension, diabetes, glaucoma, chronic iritis left eye and dry eyes. Interventions included to administer medications as ordered. Review of the electronic Physician Orders dated December 2024 included to administer brimonidine 0.2% one drop and dorzolamide-timolol drops 22.3-6.8 mg/mL to the left eye twice a day. On 12/09/24 between 9:29 A.M. and 9:45 A.M., observation revealed Licensed Practical Nurse (LPN) #401 prepared Resident #30's morning medications including brimonidine and forzolamide-timolol. LPN #401 was observed administering one drop of brimonidine to the left eye at 9:43 A.M. and one drop of dorzolamide-timolol to the left eye at 9:45 A.M On 12/09/24 at 10:18 A.M., interview with LPN #401 verified the above observation. Review of the Merative Drug Information: Dorzolamide and Timolol revised 02/01/24 revealed administration instructions including if your doctor ordered two different eye drops to be used together, wait at least five or 10 minutes between the times you apply the medicines. This will help to keep the second medicine from washing out the first one. 2. Medical record review revealed Resident #64 was readmitted on [DATE] with diagnoses including chronic atrial fibrillation, pneumonia and dry eye syndrome of bilateral lacrimal glands. Review of the careplan: At Risk for Impaired Vision (revised 11/04/24) related to aging and dry eye syndrome revealed interventions including to administer medications as ordered. Review of the electronic Physician Orders dated 12/10/24 revealed to administer Refresh Optive (carboxymethyl cellulose-glycern) 0.5-0.9 % one drop to left eye and GenTeal tears 0.1-0.3% one drop to both eyes four times a day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Altercare Zanesville Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Harrington Drive Zanesville, OH 43701	

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 between 7:49 A.M. and 8:09 A.M., observation revealed Registered Nurse (RN) #402 prepared Resident #64's morning medications including systane ultra 0.4-0 3% and GenTeal tears 0.1-0.3% to the resident's bedside. RN #402 informed the resident of the eye drops and Resident #64 stated she took systane ultra to both eyes and Genteal Tears to the left eye only. RN #402 administered the eye drops per resident instructions versus the current physician order. Pressure was not observed being applied to the inner tear duct during the above observation. On 12/10/24 at 9:25 A.M., interview with RN #402 verified the above observation and administered what the resident told her instead of following or clarifying the physician order for Resident #64's ordered eye drops. Review of the Specific Medication Administration Procedures: IIB5: Eye Drop Administration (revised May 2020) revealed if multiple medications were prescribed for administration in the same eye at the same time, wait five minutes or the specified length of time recommended per manufacturer's instructions or pharmacy labeling, then repeat procedure. If administering medications to both eyes, use a different gloved finger to apply pressure to the inner tear duct. 3. Medical record review revealed Resident #270 was readmitted on [DATE] with diagnoses including Parkinson's disease, reduced mobility and unspecified constipation. Review of the careplan: Potential for Constipation related to use/side effects of medications, impaired mobility, and history of constipation revised 11/08/24 revealed interventions included to administer medications as ordered. Review of the electronic Physician Orders dated 12/10/24 revealed to administer Senna-S (laxative) two 8. 6-50 (mg) tablets twice a day. On 12/10/24 between 8:15 A.M. and 8:27 A.M., observation revealed LPN #403 prepared Resident #270's morning medications including one tablet of Senna-S 8.6-50 (mg). On 12/10/24 at 8:27 A.M., interview with LPN #403 verified the above observation. This deficiency substantiates Complaint Number OH00160307.