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	02/18/2025

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 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** 28704 Based on observation, medical record review, policy review, national library glove use review guidance and interview, the facility failed to ensure a resident with an indwelling urinary catheter was provided appropriate care and services. This affected one resident (#2) of three residents reviewed for indwelling catheter use. The facility identified six residents with indwelling urinary catheters. The census was 93. Findings include: Medical record review revealed Resident #2 was admitted on [DATE] with diagnoses including nontraumatic intracerebral hemorrhage, dementia, aphasia, congestive heart failure, urinary tract infection, hydroureteronephrosis, bladder outlet obstruction, pyelonephritis, ureteral stent, use of an indwelling urinary catheter, and Kennedy ulcer (a rapidly developing skin wound that appears in some people during their final weeks of life). Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #2 was severely impaired for daily decision-making, had no behavioral or rejection of care, bilateral impaired upper and lower extremity functional range of motion limitation, was dependent on staff for self-care, was always incontinent of urine and did not have an indwelling urinary catheter. Review of the hospital Infectious Diseases Progress Note dated 02/06/25 and hospitalist Inpatient Progress Note dated 02/06/25 revealed diagnoses included Escherichia coli (e. coli) cystitis with chronic retained right ureteral stent with greater than 100,000 col/mL urine culture for e. coli (a gram-negative bacteria commonly found in the lower intestine). Further review of the hospital records revealed a Discharge Summary dated 02/10/25 revealed the resident was admitted to the hospital on 02/05/25 with diagnoses including a urinary tract infection requiring treatment with antibiotics and discharged back to the facility on [DATE]. Review of the electronic Physician Orders dated 02/10/25 revealed the resident was ordered a 16 french indwelling catheter to straight drain. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated Baseline care plan revealed pain approaches included the following: encourage resident to report any pain; note pain by utilizing intensity, location and pain type; note verbal (vocal) complaints of pain and non verbal restless, grimacing, withdrawal; and to medicate for pain per order and indication by the resident verbal or non verbal. Coccyx wound approaches included to monitor for pain. On 02/18/25 between 10:42 A.M. and 11:03 A.M., observation of Resident #2's indwelling catheter care revealed the following: Certified Nurse Assistant (CNA) #222, CNA #224 and Registered Nurse (RN)#266 donned personal protective equipment, gathered supplies and entered Resident #2's room to perform catheter care. CNA #222 washed her hands at the sink, donned gloves after filling a single water basin with warm water and took soap and the single wash basin to the resident's bedside. CNA #222 informed the resident she was going to perform catheter care and CNA #224 was going to roll her onto her left side. Observation of the resident laying on her back in bed revealed the indwelling catheter tubing was positioned under her left leg and was pressed against the mattress. CNA #222 grasped a washcloth and placed it into the wash basin, applied soap to the wash cloth. The indwelling catheter shaft tubing from the external urethral orifice to the urine drainage port was cleansed in a downward motion while CNA #222 was securing the catheter at the resident's urethral opening and labia. CNA #222's gloved fingers and hand was observed pressing against the external urethra and labia while the indwelling catheter tubing was cleaned. The washcloth was placed into a trash bag being held by RN #266. CNA #222 grasped a new clean washcloth without changing her gloves and placed both the wash cloth and gloved hands in the washbasin CNA #222's gloved hands were observed and moved the washcloth around the washbasin to wet it and then wrung out the excess water. CNA #222 proceeded to rinse the indwelling catheter tubing and then placed the washcloth used to rinse the tubing into the trashbag. Using the same gloves, CNA #222 then grasped a clean dry washcloth, dried the catheter tubing and then placed the washcloth in the trashbag. CNA #222 went to the resident's bathroom, dumped the washbasin water into the toilet, removed her gloves and washed her hands at the sink. CNA #222 verified the above observation and she had not changed her gloves during the procedure. On 02/18/25 between 12:25 P.M. and 12:37 P.M., interview with RN #226 verified CNA #222 did not change her gloves during catheter care and were placed in the washbasin after used to clean and then rinse/dry the resident's indwelling catheter tubing. RN #226 stated the resident had been hospitalized recently for diagnoses including a urinary tract infection and residents with indwelling catheters were at higher risk for infections. On 02/18/25 between 12:43 P.M. to 12:46 P.M., interview with CNA #222 verified the above observation. Review of the undated Policy: Catheter Care, Urinary revealed it was the facility policy to prevent infection of the resident's urinary tract. Review of the National Library of Medicine, National Institutes of Health: Glove Use dated March 2010 revealed change gloves between tasks and procedures on the same patient, and after contact with material that may contain high concentration of microorganisms. This deficiency represents non-compliance investigated under Complaint Number OH00162399.