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	03/20/2025

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 - Immediate jeopardy to resident health or safety 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** 32801 Based on closed medical record review, review of a resident communication log, review of visiting healthcare service orders, review of a customer alert form, hospital notes, policy review, medication instructions, and death certificate, and interview with family and facility staff the facility failed to ensure comprehensive monitoring and timely identification of a change in condition for Resident #94, who was incontinent of bladder with a diagnosis of Stage 3 chronic kidney disease. In addition, the facility failed to ensure Resident #94 received timely, necessary and appropriate treatment and services of a urinary tract infection (UTI). This resulted in Immediate Jeopardy, actual harm, and subsequent death beginning on [DATE] when Resident #94's daughter requested a urinalysis to be performed due to changes in the resident's cognition that was not completed by the facility. Resident #94's daughter again requested on [DATE] a urinalysis be performed as Resident #94 had increased confusion including visual hallucinations and two falls on [DATE]. On [DATE] the nurse practitioner (NP) was in the facility and ordered a urinalysis with culture and sensitivity for Resident #94, however, did not assess the resident. On [DATE] the physician ordered additional laboratory testing (a basic metabolic panel (BMP) and complete blood count (CBC). The urinalysis order was not entered into the computer system until [DATE]. The lab collected the BMP and CBC on [DATE] at 8:25 A.M., however the urine was not collected for the urinalysis. The urine specimen was finally collected and sent to the hospital lab on [DATE] for testing. On [DATE] the culture results were received indicating that the resident had Escherichia coli (E. Coli) (bacterial infection). The E. Coli infection had antibiotic susceptibility and was sensitive to Trimethoprim/Sulfa (antibiotic). The resident was started on Bactrim (antibiotic medication) orally. On [DATE] Resident #94's daughter requested the resident be transferred to the hospital due to her confusion. The resident was admitted to the hospital on [DATE] with diagnoses including sepsis secondary to UTI and met sepsis criteria. On [DATE] the resident expired at the hospital. The resident's death certificate dated [DATE] revealed the resident 's immediate cause of death was acute renal failure due to acute cystitis with an onset of days. This affected one resident (#94) of three residents reviewed for infections. The current census was 92. (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 03/20/2025
NAME OF PROVIDER OR SUPPLIER Altercare Zanesville Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Harrington Drive Zanesville, OH 43701	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:05 A.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] when Resident #94 had a change in condition including confusion with visual hallucinations and increased episodes of falling, whereas the resident's family requested urinalysis twice due to the resident's change in condition, and the facility failed to complete the requested testing and failed to notify the medical provider of the family's concerns. In addition, the resident's urinalysis with culture and sensitivity was not collected timely, therefore delaying treatment for the UTI. Resident #94 was transferred and admitted to the hospital on [DATE] per the family's request due to increased confusion. The resident expired at the hospital on [DATE] due to acute renal failure due to acute cystitis. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 10:53 A.M. all 87 current in-house residents (continent and incontinent) medical records from [DATE] to [DATE] were reviewed by the DON and Regional Nurse, for any significant change in conditions and documented signs and symptoms of urinary tract infections and appropriate notifications have been made to obtain appropriate treatment for significant change in condition if needed. This was completed [DATE] at 1:29 P.M. On [DATE] the facility laboratory testing practice of completing labs per physician's orders on Monday, Wednesday, and Friday each week unless a STAT lab was ordered by a physician was reviewed with Medical Director (MD) #301 and approved. The facility was also in contact with a local hospital regarding the possibility of initiating a contract with them for labs, to increase available lab days, which was MD #301's preference when available to begin. It was the providers preference for facility nurses to be able to communicate scheduled lab days and facility lab capabilities upon on call physician notification. On call physician would then determine if STAT labs were a necessity or if lab could be ordered for next scheduled lab day. Scheduled lab days were posted for all nurses to reference at each unit's nurse's station. Nurses were aware of where to locate reference information regarding scheduled lab days and their responsibility to communicate lab capabilities and scheduled lab days to on call physician as needed. On [DATE] the facility implemented a plan in the event of a family request for medical intervention, in that nurses need to complete a comprehensive assessment of the resident to determine if there was a necessity for emergent care or treatment rendered. The comprehensive assessment would include new onset symptoms, vitals, mental status, respiratory status, pain status, and skin assessment. After assessment if it was deemed necessary for emergent care or treatment, then the nurse would immediately notify the resident; consult with the resident's attending physician, on call physician, nurse practitioner, physician assistant or clinical nurse specialist and notify the resident's authorized representative or interested family member. The following circumstances would constitute immediate notification as outlined above: a) An accident or incident involving the resident, which results in an injury and has the potential for requiring physician intervention b) A significant change in the resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental, or psychosocial status in either life-threatening condition or clinical complications) (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c) Lab, radiology, or other diagnostic testing results that fall outside of clinical reference ranges d) A need to alter the resident's medical treatment significantly (i.e. need to discontinue medication), or to commence a new form of treatment (e.g. refusal of treatment/medications (2) or more consecutive times) e) A need or family/resident request for transfer or discharge of the resident from the facility to a hospital/treatment center (this includes transfers to the hospital as well as discharges against medical advice) f) Beginning [DATE], the facility MedOne provider would receive immediate notification regardless of nurse's comprehensive assessments regarding family requests for medical treatment. The facility plan included, if upon assessment, a necessity for emergent care or treatment was not identified, nurses would add the concern to the Resident Communication Log. The Resident Communication Log would then be reviewed for needed follow up by the Medical Director, attending physician, or Nurse Practitioner on their next rounding day. On [DATE] at 12:06 P.M. the DON provided nurses education (either in person or by phone) on proper notification of significant changes in residents' conditions as outlined above. As of 5:34 P.M. on [DATE], 21 of 21 facility nurses have been educated on the above topics. No new nurses would be permitted to work until they have received education on the above topics. On [DATE] at 1:28 P.M. the DON provided nurses education (either in person or by phone) on signs and symptoms of UTIs per McGeer's criteria. On [DATE] at 1:30 P.M. an Ad hoc Quality Assessment Performance Improvement (QAPI) meeting was held with the Administrator, DON, Assistant Director of Nursing (ADON), Medical Director (MD) #301 and Regional Nurse in regard to proper notification of significant changes in residents' conditions and signs and symptoms of UTIs per McGeer's criteria. Review of Notifications of Change in Condition policy was completed at this time. MD #301 was in agreement with procedure for Notifications of Changes as outlined in this policy. Beginning [DATE] the DON or designee would conduct daily audits of all in-house resident records including the Resident Communication Log to ensure any significant change of condition has been reported to the appropriate personnel and treatment was obtained if deemed necessary by physician/CNP/On-Call service, for two weeks, then three times per week for two weeks, then weekly for two weeks and then as needed (PRN). Beginning [DATE], the DON or designee would conduct daily audits of all in-house resident records including Resident Communication Log to ensure documented signs and symptoms of urinary tract infections and the appropriate notifications have been made to obtain appropriate treatment if ordered daily for two weeks, then three times per week for two weeks, then weekly for two weeks and then as needed (PRN). (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor interviews completed on [DATE] at 9:32 A.M. and 10:02 A.M., with Licensed Practical Nurse (LPN) #190 and Registered Nurse (RN) #203 confirmed they were educated yesterday [DATE] on change of condition, documentation, and signs and symptoms of UTI. Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #94's closed medical record revealed the resident was admitted to the facility on [DATE] following a hospitalization from [DATE] to [DATE] where the resident had back surgery. The resident's diagnoses included fusion of the spine, lumbar region, spinal stenosis, history of transient ischemic attack, atrial fibrillation, chronic diastolic heart failure, hypertension, type 2 diabetes, Stage 3 chronic kidney disease (mild to moderate loss of kidney function), anemia, depression, anxiety, sleep apnea, nonalcoholic steatohepatitis, tremor, hyperlipemia, and gastro-esophageal reflux. The resident was discharged to the hospital on [DATE] and did not return to the facility. The resident passed away at the hospital on [DATE]. Review of Resident #94's admission assessment dated [DATE] and completed [DATE] revealed the resident had short- and long-term memory impairment and was alert to self only. The resident was able to make needs known, understand others, and her speech was clear. The assessment revealed the resident was incontinent of urine at times. A baseline care plan indicated staff would observe (urine) for burning, odor, complaints of pressure, increase confusion, abdominal pain, fever and notify the provider as warranted. The resident's plan was to return home following her stay at the facility. Review of Resident #94's skilled note authored by Licensed Practical Nurse (LPN) #190 dated [DATE] revealed the resident was restless, confused/disoriented, only alert to self, incontinent of urine, and had mild pain (this was a check box on a form and did not describe the pain or specify the location of the pain). Review of Resident #94's history and physical note authored by Physician #301 dated [DATE] revealed the resident was seen for diabetes, diabetic fibrosis, and lumbar spinal stenosis post-surgery. The resident had a posterior lumbar interbody fusion that was performed on [DATE] and was stabilized and transferred to the skilled nursing facility for ongoing care and therapy. The resident was alert and oriented times three with mentation slightly slow. There were no new concerns per nursing staff. The resident stated her lumbar pain and leg pain was much improved since decompression. The note revealed the resident was incontinent and had no suprapubic tenderness. Staff reported the resident's memory was poor. Review of an incident reassessment summary (unauthored) dated [DATE] revealed the resident had fallen ambulating back from the bathroom. The resident was assisted times two (staff) to her feet and to the bathroom. No injuries noted. Immediate intervention was to encourage resident to use call light for transfers/ambulation assistance and therapy to screen for treatment as indicated. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #94's orders dated [DATE] revealed laboratory testing orders for a Basic Metabolic Panel (BMP) (includes glucose, sodium, potassium. Chloride, carbon dioxide, creatinine, blood urea nitrogen (BUN), and calcium) and Complete Blood Count (CBC) (red blood cells, hemoglobin, hematocrit, white blood cells (also measure differentials which is the breakdown of different types of white blood cells, and platelets). However, there was no evidence the BMP or CBC were collected as ordered at this time. Review of Resident #94's skilled note authored by Registered Nurse (RN) #195 dated [DATE] revealed the resident was alert and oriented time three, no urine difficulties, however had severe pain. There was no additional information at this time related to the resident's severe pain, etiology of the pain and/or interventions to address the complaints of pain. Review of Resident #94's progress note dated [DATE] authored by Registered Nurse (RN) #195 revealed at 12:42 A.M. the resident was having general discomfort and non-pharmacological interventions (NPI) were ineffective. Medicated with two Norco's (schedule II opioid narcotic). At 6:43 A.M., resident complained of general discomfort and headache. NPI's not effective and medicated with two Norco's at 5:37 A.M. There was no evidence that the physician and/or nurse practitioner were notified at this time. Review of Resident #94's skilled note authored by RN #195 dated [DATE] revealed the resident was alert and oriented times three, no urine difficulties, or pain. Review of Resident #94's skilled note authored by RN #196 dated [DATE] revealed the resident was alert and oriented times three, no urine difficulties, or pain. Review of Resident #94's skilled note authored by RN #195 dated [DATE] revealed the resident was alert and oriented times three, no urine difficulties, or pain. Review of Resident #94's incident reassessment summary (unauthored) dated [DATE] at 2:45 P.M., revealed the resident had fallen in her room. Resident reported she was getting up to go to the bathroom and fell . The resident had no injuries noted and was assisted up times three to the bed and then to the bathroom. Intervention identified non-skid socks applied and the resident was educated to wear non-skid socks as tolerated. Review of Resident #94's progress note dated [DATE] authored by RN #195 revealed resident had complaints of back discomfort. NPI's ineffective. Resident was medicated at 8:43 P.M., with Norco. There was no evidence the physician and/or nurse practitioner were notified at this time. Review of Resident #94's incident reassessment summary (unauthored) dated [DATE] at 11:06 P.M., revealed the resident was found lying on the right side of the recliner. No injuries noted. The resident was assisted up times two (staff) and assisted to bed. New interventions implemented were bed in lowest position when in bed and bed against wall to promote spaciousness. (This fall is the second fall on this date). (continued on next page)

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F 0690

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Review of a Resident Communication Log (log was to be used for non-emergent issues that could be addressed at next provider rounds) dated [DATE] to [DATE] revealed on [DATE] Resident #94's name was on the top of log and the concern indicated the resident's daughter wanted the resident checked for a urinary tract infection (UTI). On [DATE] Resident #94's name was listed again and the concern indicated resident was showing signs of restlessness. Resident noted getting out of bed/chair without assistance. Daughter wants a urinalysis (UA). At the bottom of the form there was a typed note (in all capital letters) ANY NEW ONSET SYMPTOMS OF COUGH, BLEEDING, CHANGE IN MENTAL STATUS, ABNORMAL VITALS, AND CRITICAL LABS NEED CALLED IMMEDIATELY!

Review of Resident #94's skilled note authored by Licensed Practical Nurse (LPN) #165 dated [DATE] revealed the resident was restless, confused/disoriented, alert to self only, no urinary difficulties, or pain.

Review of Resident #94's progress notes dated [DATE] and [DATE] revealed no evidence the resident's medical provider was updated on the family's request to have urine (UA) checked. In addition, there was no evidence the resident had been assessed by a medical provider since [DATE] when Physician #301 completed the resident's history and physical.

Review of Resident #94's Admission Minimum Data Set (MDS) 3.0 dated [DATE] revealed the resident's brief mental status (BIMS) score was 11, reflecting she was moderately cognitively impaired. The assessment revealed the resident required partial/moderate (staff) assistance with toileting hygiene, dressing, putting on and taking off footwear, and personal hygiene. The resident had no impairment with range of motion. The assessment revealed the resident was occasionally incontinent of urine and not on a toileting program.

Review of Resident #94's orders dated [DATE] revealed an order for laboratory testing for a Basic Metabolic Panel (BMP) and Complete Blood Count (CBC). However, there was no evidence that BMP or CBC was collected as ordered on this date.

Review of Resident #94's skilled note authored by RN #195 dated [DATE] revealed the resident was alert to self, no urine difficulties, or pain.

Review of Resident #94's progress note dated [DATE] at 6:40 A.M., authored by RN #195 revealed the resident had complaints of back pain. NPI's were ineffective and Norco was administered at 1:11 A.M. There was no evidence the physician and/or nurse practitioner were notified at this time and/or evidence the facility investigated to determine the etiology of the back pain.

Review of a visiting healthcare service order sheet dated [DATE] revealed Nurse Practitioner (NP) #302 ordered Resident #94 to have a urinalysis (UA) with culture and sensitivity (C&S). (This is a note written by the medical provider to include the resident's name and orders which are then later entered into the electronic medical record)

Review of Resident #94's orders dated [DATE] revealed an order for a Basic Metabolic Panel (BMP) and Complete Blood Count (CBC). However, there was no evidence that the BMP or CBC was collected and there was no evidence there was an order written for UA C&S.

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #94's skilled note authored by RN #196 dated [DATE] revealed the resident was alert and place, heart rate was irregular, no urine difficulties, and pain was rated six out of 10 (,d+[DATE] pain scale). There was no evidence the physician and/or nurse practitioner were notified at this time and/or evidence the facility investigated to determine the etiology of the resident's pain or irregular heart rate at this time. Review of a communication log from the on-call physician services dated [DATE] authored by NP #302 revealed the resident had chest pain with stable vital signs, pain seen left lateral (side) with deep breaths. Orders were provided for the medication, Maalox twice today and daily for three days and a chest x-ray. In addition, NP #302 order inhalation medication, DuoNeb every eight hours for 10 days. Review of Resident #94's physician orders dated [DATE] revealed NP #302 ordered a urine culture to be obtained (there was no diagnosis for the test). In addition, Physician #301 ordered a straight cath to obtain urine for culture and sensitivity with no indication or diagnosis listed, DuoNeb every eight hours with no diagnoses or indication noted, Maalox 30 milliliters (ml) now and 30 ml twice daily with no indication for use, and a STAT chest x-ray to rule out infection for symptoms of left side pain, decreased oxygen saturation levels, and increased confusion. Further review revealed no evidence Resident #94 was actually seen or assessed by a medical provider (physician or nurse practitioner from [DATE] through [DATE]. Review of Resident #94's medication administration record dated [DATE] to [DATE] revealed the resident received two doses of Maalox on [DATE], [DATE], and [DATE] which was different from the order on the communication log. The DuoNeb was started every eight hours on [DATE] at 8:00 A.M. (ordered on [DATE]). There was no indication for use/diagnoses. Review of Resident #94's BMP and CBC results dated [DATE] revealed the resident's blood was collected at 8:25 A.M., however the urine was not collected. The resident's sodium was 135 low (,d+[DATE] milliequivalents/liter (mEq/L)), chloride was 95 low (,d+[DATE] mEq/L)), red blood cells 3.76 low (3XXX, d+[DATE].40 million cells/microliter (mL), hemoglobin 11.4 low (,d+[DATE] grams/deciliter (g/dL) and hematocrit was 33.9 low (,d+[DATE] percentage (%)). (There was no documented evidence a medical provider was notified of the abnormal lab results until a resident progress note dated [DATE] at 2:45 P.M. authored by the DON which included the final lab results and chest x-ray results were reviewed by NP #302, there were no new orders at this time.) Review of Resident #94's progress note dated [DATE] at 12:15 P.M. (after labs were already obtained at 8:25 A.M., that morning) authored by RN #109 revealed he attempted to collect urine sample on resident via straight cath and was not able to collect. The resident was unable to follow directions for clean catch specimen. Other unit nurse to attempt urine collection when resident's daughter arrives to alleviate mental strain on resident. Review of Resident #94's skilled note authored by RN #195 dated [DATE] revealed the resident was alert and oriented times three, no urine difficulties, or pain. There was no documented evidence the resident had chest pain or low oxygen at this time. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #94's chest x-ray dated [DATE] revealed no evidence of acute cardiopulmonary disease. Review of Resident #94's treatment administration record dated [DATE] to [DATE] revealed the resident's oxygen saturation via pulse oximetry was 93% to 99%. On [DATE] Resident #94 pulse ox was 95% and 97% (this note did not include if this was on room air or if the resident was receiving supplemental oxygen). Review of Resident #94's urinary incontinence plan of care dated [DATE] revealed the resident was incontinent of bladder and was at risk for altered dignity, skin breakdown, and urinary tract infections (UTI). Interventions included to observe/report any signs and symptoms of UTI such as resident complaints of pain or burning with urination, complaints of pressure, odor, discoloration of urine, and mood/behavior changes. Review of Resident #94's progress note dated [DATE] at 8:27 A.M. authored by Licensed Practical Nurse (LPN) #150 revealed Resident #94's urine was collected and sent to lab. (Five days after the resident's daughter had first requested the specimen be obtained). Review of Resident #94's skilled note authored by LPN #150 dated [DATE] revealed the resident was confused/disoriented, alert to self and place only, had frequent urination, and no pain. Review of Resident #94's skilled note authored by RN #196 dated [DATE] revealed the resident was alert and oriented time three, no urine difficulties, or pain. Review of a customer alert notice authored by the DON dated [DATE] revealed Resident #94's daughter had voiced concerns regarding the timeframe for lab testing at the facility. Preliminary lab results reviewed, and the daughter was informed the UA takes 72 hours to process per the lab. The resident's daughter was educated that lab draws and specimens were completed on Monday, Wednesday, and Fridays per the facility's services, but that the facility would send any cultures to the local lab as needed. A copy of the resident communication log and visiting healthcare service order sheet was attached to the notice. Review of Resident #94's UA results dated [DATE] revealed the urine was collected on [DATE] at 6:00 P.M., and received on [DATE] at 12:29 P.M. The diagnosis listed was dysuria (discomfort, pain or burning when urinating). The urine culture grew greater than 100,000 milliliters (ml) of Escherichia coli (E. Coli). The bacteria was sensitive to Trimethoprim/Sulfa. Review of Resident #94's progress note dated [DATE] authored by LPN #150 revealed final (urine) report received. New orders for antibiotic for urinary tract infection (UTI). Give first dose now and encourage fluids. Review of Resident #94's skilled note authored by LPN #150 dated [DATE] revealed the resident was alert to self and place, incontinent of urine and had no pain. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #94's infection tracker with McGeer's criteria dated [DATE] revealed the resident had UTI that was a healthcare-associated infection. The resident had no indwelling catheter. The resident had acute dysuria or acute pain, swelling, or tenderness of the testes, epididymis, or prostate and had at least 100,000 cfu/ml of no more than two species of microorganisms in a voided urine sample. The resident met criteria for McGeer's for non-catheter UTI. The resident had history of signs and symptoms of UTI including cloudy or dark urine, pain or burning, pain or burning during urination, and low-grade fever. The urine culture showed greater than 100,000 cfu/ml of E.Coli. Note- this information contained in Resident #94's infection tracker related to the resident's dysuria and cloudy dark urine was not included in the resident's medical record. Review of Resident #94's orders and medication administration records dated [DATE] revealed the resident was ordered Bactrim (sulfa antibiotic) 800 milligrams (mg) twice daily orally. The resident received one dose of Bactrim 800 milligrams (mg) on [DATE], two doses on [DATE], and one dose on [DATE]. Review of Resident #94's skilled note authored by LPN #140 dated [DATE] revealed the resident was alert and oriented time three, no urine difficulties, or pain. Review of Resident #94's skilled note authored by RN #196 dated [DATE] revealed the resident was confused/disoriented, alert to self only, incontinent of urine and denied shortness of breath and chest pain. Review of Resident #94's skilled note authored by RN #116 dated [DATE] revealed the resident was restless/confuses/delusional, alert to self, had irregular heart rate, and was incontinent of urine. Review of Resident #94's progress note authored by RN #116 dated [DATE] revealed at 1:45 P.M., the resident's family member requested the resident be sent to the hospital, for evaluation for confusion. This nurse educated the family that confusion was an expected symptom of urinary tract infection. The note revealed the family member insisted the resident be sent out to the hospital. At 1:50 P.M., NP #302 was notified, and an order was received to transfer the resident to the hospital per family's request. Review of Resident #94's medical provider notes revealed no evidence the resident had been seen by a medical provider from [DATE] to [DATE]. Review of Resident #94's observation report (transfer form) dated [DATE] and closed [DATE] revealed the resident's daughter was present at time of transfer. The daughter requested that the resident be sent to hospital. The observation report documented the resident's baseline mental status was confused and the resident was continent of bladder. However, review of medical record notes prior to this date included the resident had been alert and oriented times three and incontinent on various occasions. Review of Resident #94's progress note dated [DATE] at 8:46 A.M., revealed the resident was admitted to the hospital with sepsis (life threatening complication of an infection) secondary to UTI and met sepsis criteria. (continued on next page)

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 03/20/2025
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)
F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #94's hospital notes authored by Emergency Physician #401 dated [DATE] revealed the resident was in the emergency room for UTI. The resident had started Bactrim on Saturday after being diagnosed with UTI. Symptoms were worsening. Shaking possible rigors, chills, fever, back pain, and altered mental status. Review of Resident #94's hospital note authored by Hospitalist #402 dated [DATE] revealed the resident had acute cystitis and had tested positive on [DATE] for E. coli in the urine. The resident started on Bactrim on [DATE] with reported increased confusion. The resident was transitioned to the antibiotic Levaquin. The resident had acute kidney injury likely secondary to hypovolemia (low blood volume due to injury, illness, or underlying condition) and recent Bactrim. The note included the resident had acute metabolic encephalopathy in the setting of acute cystitis which was likely worsening due to Bactrim and hypovolemia. Review of Resident #94's discharge hospital note authored by Hospitalist #400 dated [DATE] revealed on [DATE] the resident presented to the hospital with altered mental status. She was admitted with a heart rate of 104, respirations were 24, lactate level 2.2, and positive UA. The resident was assessed to have acute cystitis and acute kidney injury (AKI) on chronic kidney disease 3. The AKI was likely secondary to hypovolemia and recent Bactrim use. Sepsis was secondary to acute cystitis. Although the acute metabolic encephalopathy etiology was unclear, the note included in the setting of acute cystitis complicated with Bactrim administration versus hypovolemia, versus polypharmacy, versus hypoglycemia. The resident was made comfort care only on [DATE] and expired on [DATE]. Review of Resident #94's death certificate dated [DATE] revealed the resident's immediate cause of death was acute renal failure due to acute cystitis and the onset was days. Interview on [DATE] at 2:27 P.M., with the DON, Administrator, and Corporate Nurse #300 confirmed the family had requested a urinalysis (UA) be obtained on [DATE] and [DATE], however nursing staff believed collecting a UA was not urgent and wrote the request on the resident communication log (for the practitioner to see when next in the building as opposed to contacting the provider at that time). The administrative staff verified the communication log was used for non-emergent issues that could be addressed at next rounds by the provider and indicated the nurse practitioner comes (to the facility) three days a week and the physician visits once a week. On Thursday, Saturday, and Sundays there are no medical providers in the facility. After 6:00 P.M. and on weekends the staff can call the on-call service to reach a covering medical provider. The DON confirmed there was no documentation that a medical provider was notified on [DATE] or [DATE] the family wanted a UA checked nor was there documented evidence the resident's urine was checked at the facility. The DON reported staff could have obtained a urine specimen (onsite) to check for infection prior to sending a urine to the lab. On [DATE] NP #302 reviewed the communication form and ordered a UA due to the family having requested it (although they believed the NP did not feel the testing was necessary). The administrative staff also verified on [DATE] Resident #94's daughter voiced concerns regarding the timeliness of UA and the DON reported she explained to the daughter that the lab only comes on Monday, Wednesday, and Fridays. The DON confirmed the UA was ordered on [DATE]; however, it was not collected until [DATE] and sent out on [DATE] to a local lab and not the facility's contracted lab. On [DATE] the urine C&S came back positive for the bacteria E. Coli and NP #302 ordered Bactrim DS twice daily. The administrative staff verified on [DATE] the family requested the resident be transferred to the hospital where she was admitted w [TRUNCATED]

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 03/20/2025
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)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review and interview the facility failed to ensure a resident received laboratory services per physician orders. This affected one resident (#65) of four residents reviewed. Findings included: Review of Resident #65's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including encephalopathy, atrial fibrillation (new onset), sleep apnea, hypertension, chronic kidney disease, Stage 4, bradycardia, transient cerebral ischemic attack, and bladder-neck obstruction. Review of Resident #65's orders dated 02/26/25 revealed the resident was to have a basic metabolic panel (BMP) every Friday until 03/15/25. There were no diagnoses or indications why the BMP was ordered. Review of Resident #65's treatment administration records (TAR) dated 02/22/25 to 03/13/25 revealed staff signed off the BMP was collected on 02/28/25 and 03/07/25. Review of Resident #65's medical record revealed no evidence a BMP was obtained on 02/28/25 or 03/07/25 per order. Review of Resident #65's physician note dated 02/25/25 revealed the resident had chronic kidney disease Stage 4 and coronary arteriosclerosis and to check BMP periodically. Interview on 03/13/25 at 2:27 P.M., with the Director of Nursing (DON), Administrator, and Corporate Nurse #300 confirmed there was no evidence the BMP was obtained on 02/28/25 or 03/07/25 per order for Resident #65. The DON confirmed there was no documented evidence why the BMP was not collected on 02/28/25 or 03/07/25. The surveyor asked the facility to provide additional information about why the BMP was ordered every Friday until 03/15/25. Interview on 03/13/25 at 4:58 P.M., with the DON revealed on 02/25/25 the physician had documented in the history and physical to check BMP periodically for coronary arteriosclerosis. Interview on 03/13/25 at 5:00 P.M., with the Administrator revealed the facility did not have a policy on laboratory services and the facility would just follow physician orders. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00163321.