

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  05/01/2025
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52003</b></p> <p>Based on observation, medical record review and interview, the facility failed to follow insulin administration and blood glucose monitoring per physician orders. This affected one resident (Resident #79) of three residents reviewed for insulin use. The facility census was 82.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #79 revealed an admitted [DATE]. Diagnosis included type 2 diabetes, atherosclerotic heart disease of native coronary artery without angina pectoris and presence of aortocoronary bypass graft.</p> <p>Review of orders for March 2025 revealed Lantus (long acting insulin) insulin 42 units subcutaneous once a day started on 03/03/25, Insulin Lispro seven units three times a day before meals and per sliding scale dated 03/03/25.</p> <p>Review of the Minimum data Set (MDS) dated [DATE] revealed intact cognition. Resident #79 received insulin injections seven days during the assessment period.</p> <p>Review of medical record revealed Resident #79 was out of the facility to an endocrinology appointment on 03/26/25 at 9:00 AM.</p> <p>Review of the provider note dated 03/26/25 revealed continue lispro seven units before meals, two units for 50 points above 150 and lantus 42 units daily, will order freestyle libre.</p> <p>Review of the physician orders revealed Freestyle Libre 3 plus sensor (blood-glucose sensor) device apply once every 14 days started on 03/26/25. In addition, on 03/26/25 Insulin Lispro was discontinued, and blood sugars were not obtained.</p> <p>Review of the March and April 2025 Medication Administration Records (MAR) revealed Resident #79 stopped receiving Insulin Lispro routinely and as needed on 03/26/25 and monitoring blood sugars were not continued since 03/26/25. Resident #79 started the blood glucose monitor device on 03/28/25.</p> <p>Interview and observation on 04/28/25 at 12:07 PM with Resident #79 revealed her Freestyle Libre 3 plus sensor (glucose monitoring disc) came off and she stated she had to wait two weeks to get a new one. Resident #79 also stated staff have not been monitoring her blood sugars for some time. Observation at that time revealed Resident #79 did not have her glucose monitoring disc on.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/30/25 at 11:42 A.M. with RN #300 from the endocrinologist's office revealed Resident #79 was seen in the office on 03/26/25 for diabetes management. RN #300 verified Resident #79 had orders for Lantus 42 units once daily and insulin Lispro seven units three times a day before meals and sliding scale two units for every 50 points above 150 (blood glucose level). Resident #79 also started on a blood sugar monitor device at that time. RN #300 stated the facility should have called and verified the orders if they did not understand them. Resident #79's blood sugar should be checked at least three times a day. RN #300 stated on the physician note, it said to continue to check blood sugars and continue insulin as ordered.</p> <p>Interview on 04/30/25 at 2:00 P.M. with the DON and Regional Nurse #439 verified the nurse that received the orders should have verified the orders with the physician. The DON verified Resident #79 did not receive monitoring of blood sugars from 03/26/25 through 04/30/25 except when she had a blood draw. DON verified on 03/26/25 Resident #79's fast acting insulin was discontinued and was not given per physician orders.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52003</p> <p>Based on observation, medical record review and interview and policy review the facility failed to ensure personal protective equipment (PPE) was worn in Resident #6's room during meal delivery. This had the potential to affect the remaining 26 residents who resided on the 300-hall. (Resident #2, #5, #9, #12, #20, #21, #29, #31, #35, #39, #43, #44, #45, #47, #48, #49, #54, #59, #62, #63, #65, #67, #70, #76, #184 and #185). The facility census was 82.</p> <p>Findings Include:</p> <p>Review of Resident #6's medical record revealed an admitted [DATE] with diagnoses including infection following a procedure, acquired absence of right leg above knee, muscle weakness, and Methicillin Resistant Staphylococcus Aureus infection (MRSA) (a bacterial infection resistant to many antibiotics that is spread by skin to skin contact or contact with contaminated surfaces).</p> <p>Review of physician orders indicated Resident #6 required contact transmission-based precautions due to MRSA.</p> <p>Observation on 04/30/25 at 4:18 P.M. revealed the Director of Nutrition Services #425 entered a contact isolation room for Resident #6 during the evening meal tray delivery. A sign was posted outside of Resident #6's room indicating she was on contact precautions and a cart containing personal protective supplies was noted below the sign and outside the resident's room door. The Director of Nutrition Services #425 was not wearing PPE and did not wash/sanitize hands prior to entering or exiting the room. The Director of Nutrition Services #425 obtained a Styrofoam cup from another area in the hall and poured hot water in the cup for hot tea and took the hot tea into Resident #6's room.</p> <p>Interview on 04/30/25 at 4:22 PM with the Director of Nutrition Services #425 verified he did not follow the guidance for contact isolation and should have donned PPE before entering Resident #6's room and washed his hands after exiting the resident's room.</p> <p>Review of facility policy titled Isolation-Categories of Transmission Based Precautions, updated 11/2020 revealed</p> <p>Gloves and handwashing- In addition to wearing gloves, as outlined under standard precautions, wear gloves when entering room. Remove gloves before leaving room and wash hands immediately with an Antimicrobial agent or a waterless antiseptic agent. Gown- In addition to wearing a gown as outlined under standard precautions, wear a gown (clean, nonsterile) when entering the room.</p>		