| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365394 | A. Building<br>B. Wing | 02/01/2023 |

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| Continuing Healthcare at Adams Lane | 1856 Adams Lane<br>Zanesville, OH 43701 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923<br><br>Based on record review, review of facility self-reported incident (SRI) tracking number 231321, review of the facility's investigation related to the SRI, review of law enforcement reports, staff interview, and review of the facility Abuse and Visitation policy and procedures, the facility failed to ensure Resident #76, who was cognitively impaired and resided on the secured memory care unit was free from verbal, mental, physical, and potential sexual abuse following admission to the facility on [DATE]. Between 01/02/23 and 01/21/23, the facility's staff identified and/or observed at least five incidents of interactions reflective of abuse toward Resident #76, by her husband, while he was visiting in the facility. This resulted in Immediate Jeopardy beginning on 01/07/23, after Resident #76's husband was observed to be verbally/mentally abusive to the resident while he was assisting her with personal care. The incident was reported to the unit manager with no interventions initiated. Four additional incidents of actual/suspected abuse occurred (after the initial incident of abuse by the husband) to Resident #76 that were not prevented and either not reported or not investigated by the facility. As a result, the facility failed to ensure Resident #76 was free from situations of abuse, failed to timely implement effective interventions to prevent the incidents from occurring and allowed the resident's husband to continue to visit the resident unsupervised. Resident #76's husband continued to visit Resident #76 until an incident of alleged sexual abuse occurred on 01/21/23, which resulted in the husband being restricted from visiting pending the facility and local law enforcement investigations. Actual/potential physical and psychosocial harm occurred to Resident #76 as a result of the incidents of ongoing abuse including the incident on 01/21/23 when staff heard the resident crying, yelling out no and found the resident to be visibly upset. This affected one resident (#76) of one resident reviewed for abuse. The facility census was 103.<br><br>On 01/26/23 at 10:36 A.M., the Administrator was notified Immediate Jeopardy began on 01/07/23 when Resident #76 was observed to be verbally/ mentally abused by her husband while he was visiting in the facility and initial reporting of the abuse was not then reported to the facility's Administrator resulting in no investigation being completed. Resident #76 endured four other incidents of actual/ suspected/potential abuse at the hands of her husband with no intervention from the facility to prevent the incidents or further abuse from occurring. It was not until the last incident of suspected sexual abuse (on 01/21/23), that an investigation was completed, and Resident #76's husband was restricted from visiting at the direction of local law enforcement pending their criminal investigation.<br><br>The Immediate Jeopardy was removed on 01/26/23 when the facility implemented the following corrective actions:<br><br>(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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/21/23 at 3:00 P.M. State tested Nursing Assistant (STNA) #120 witnessed an incident between Resident #76 and her husband. STNA #120 told the resident's husband to leave and Licensed Practical Nurse (LPN) #88 called the local sheriff's department. At 3:30 P.M. the Muskingum County Sheriff Department arrived at the facility and interviewed the LPN #88, two STNAs, Resident #76, and Resident #76's husband and removed him from the facility.<br><br>On 01/21/23 at 4:00 P.M. the Director of Nursing and Administrator were notified by LPN #79 of the incident by phone.<br><br>On 01/21/23 at 4:15 P.M. the LPN #88 completed the skin assessment on Resident #76 and relayed the findings to the Nurse Practitioner (NP) #400, who gave the order to be sent to the emergency room (ER) for evaluation. The resident returned to the facility on [DATE] at 1:09 A.M. in stable condition.<br><br>On 01/23/23 at 10:30 A.M. the Administrator met with a detective from the Muskingum County Sheriff's Department and went over the incident with him. The detective took pictures of the room and spoke with Resident #76. Also, at this time a dog leash was retrieved from Resident #76 dresser drawer and given to the detective. The detective stated he would keep in contact with the Administrator as to what the next steps for the case would be.<br><br>On 01/23/23 at 4:47 P.M. Social Service Designee (SSD) #200 contacted the probate court to inquire about getting emergency guardianship for Resident #76. SSD #200 also left a message for the Ombudsman for guidance related to the incident.<br><br>On 01/24/23, at 9:30 A.M. the Administrator spoke with the detective from the Muskingum County Sheriff's department. The detective stated Resident #76's husband had been instructed that if he arrived on the premises of the facility he would be arrested.<br><br>On 01/24/23 at 10:00 A.M. one on one education for staff present and via phone call for staff not present was provided related to the facility abuse policy, which included what abuse was and reporting requirements was initiated by the DON/Designee and the Human Resource Director for all 117 staff members which included eight RNs, 22 LPNs, three Medical Assistants, 23, STNAs, one Activity Director, three Activity Aides, one Physical Therapist, one Occupational Therapist, three Speech Therapists, two COTAs, three PTAs, one Dietary Supervisor, one Dietary Manager, four Dietary Aides, 14 Cooks, one Human Resource Manager, one Medical Records Manager, one Central Supply/EVS Supervisor, two Receptionists, two Resident Assessment Coordinators, one Social Service Designee, one Admissions Director, one Transportation Coordinator, seven Housekeepers, five Laundry Staff, and three Maintenance staff. A plan for any staff member not educated to not work until education was completed was implemented.<br><br>On 01/25/23 at 11:03 A.M. Social Service Designee #200 spoke with Resident #76's husband and informed him Resident #76 would not be discharging from the facility (the resident had initially been admitted for short term rehabilitation).<br><br>On 01/25/23 at 3:38 P.M. Social Service Designee #200 spoke with the Ombudsman regarding emergency guardianship for Resident #76. The Ombudsman gave Social Service Designee #200 information. SSD #200 made a call to the county Social Worker (SW) who does guardianships and message left.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/25/23 at 4:00 P.M. the facility Medical Director completed an expert evaluation for Resident #76 and deemed that she was incompetent. This information will assist in establishing guardianship for the resident.<br><br>On 01/26/23 at 10:40 A.M. interviews were started by Management staff comprised of the Activity Director, Central Supply Manager, Medical Records Director, Social Service Designee, Admissions Director, and Activity Assistant for 46 residents with a Brief Interview for Mental Status (BIMS) score greater than 13 using the facility Resident Abuse Questionnaire with questions consisting of: Has anyone made you feel afraid or humiliated degraded, said mean things to you, hurt you, made you feel uncomfortable? Have you seen or heard of any residents being treated in any of these ways? If so, did you tell anyone about what happened? No new concerns were identified by the facility following these interviews.<br><br>On 01/26/23 at 10:40 A.M. education was started by the Human Resource Manager to all staff regarding the fact Resident #76's husband was not permitted at the facility and facility visitation policy, which included restricting visitation if a visitor was intoxicated and/or belligerent. As of 01/26/23 at 117 staff members had completed the education. The facility implemented a plan that any staff member who had not been educated would be educated prior to their next worked shift.<br><br>On 01/26/23 at 10:50 A.M. a Facility Quality Assessment and Assurance Committee ADHOC meeting was held by phone with the Facility Medical Director, Administrator, and RN, and Certus Clinical Support Nurse #415 regarding incidents of abuse involving Resident #76 which occurred on 01/07/23, 01/12/23, an unknown date, 01/20/23, and 01/21/23 and what corrective action measures were being taken.<br><br>On 01/26/23 at 11:00 A.M. RN, Certus Clinical Support Nurse #420 completed re-education regarding the facility abuse policy, including reporting and that even spouses could be abusers. Education was also provided related to the facility visitation policy that included restricting visitation to anyone who was intoxicated and/or belligerent with the Administrator, Director of Nursing via phone, LPN Unit Manager for halls 500, 600, and 700 and LPN Unit Manager for halls 100, 200, and secured unit.<br><br>On 01/26/23 from 11:15 A.M. to 12:24 P.M. skin inspections were performed by LPN #250 Unit Manager for 500, 600, 700 halls and LPN Unit Manager 100, 200, and secured unit for 45 residents with a BIMS score less than 13. No abnormalities were found by the staff completing the inspections.<br><br>On 01/26/23 at 12:30 P.M. Administrator, spoke with Social Worker regarding emergency guardianship of Resident #76. Social Worker emailed a Supplement for Emergency Guardian of Person to Administrator for Medical Director to complete. Medical Director completed at 1:15 P.M.<br><br>On 01/26/23 at 1:00 P.M. RN Clinical Support Nurse #415 and Transportation Coordinator initiated employee interviews related to staff witnessing abuse or potential abuse for all staff. A plan for any staff not interviewed during this time to be interviewed prior to their next scheduled shift was implemented following the interviews.<br><br>On 01/26/23 at 2:37 P.M. the Administrator emailed the Social Worker a signed service agreement and the completed supplement for emergency guardian of person forms for Resident #76.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/26/23 at 3:10 P.M. RN, Certus Clinical Support Nurse completed an audit of 37 residents with frequent visitors. Of the list, none were identified as potential resident abusers or ones who could cause harm.<br><br>On 01/27/23 at 2:16 P.M. emergency guardianship was granted by the Probate Court of Muskingum County for Resident #76.<br><br>Beginning 01/27/23, during the morning interdisciplinary team (IDT) meeting the facility would discuss if any new allegations or concerns of abuse had been brought to anyone staff members attention as well as reviewing 24-hour report. The facility indicated any/all allegations would be thoroughly investigated, and actions would be taken to ensure the facility was following the abuse policy. The facility identified the deficient practice occurred related to a failure to address and report suspicious behavior of Resident #76's husband per facility abuse policy.<br><br>Beginning 01/30/23 the Director of Nursing or her designee would conduct an audit of 10 employees using the Staff Abuse questionnaire. The audit would be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality Assurance and Performance Committee for ongoing compliance.<br><br>Beginning 01/30/23 the Director of Nursing or her designee would conduct an audit of 10 residents using the Resident Abuse Interview Tool and the skin assessment. The audit would be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality assurance and Performance Committee for ongoing compliance.<br><br>On 01/30/23 from 9:01 A.M. to 9:28 A.M. interviews were conducted by the surveyor with one housekeeper, three STNAs, and two LPNs to confirm they received training on the facility's abuse and visitation policy. All staff interviewed confirmed receiving the training and exhibited an understanding of the training received.<br><br>Although the Immediate Jeopardy was removed on 01/26/23, the facility remained 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 actions and monitoring to ensure on-going compliance.<br><br>Findings Include:<br><br>A review of Resident #76's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia and major depressive disorder. the resident was admitted to the facility secured dementia unit at the time of her admission.<br><br>A review of Resident #76's profile in the electronic health record (EHR) identified her spouse as her emergency contact #1. No other family members were identified as an emergency contact.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of Resident #76's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had adequate hearing without the use of a hearing aid. Her vision was adequate without the use of any corrective lenses. Her speech was clear, and she was able to make herself understood and was able to understand others. The assessment noted the resident had severely impaired cognition. She was not known to display any behaviors, nor was she known to reject care during the seven days of her assessment period. The assessment revealed the resident required extensive assist from two staff for transfers, extensive assist from one staff for locomotion on and off the unit, dressing and toilet use and limited assistance from one staff for ambulation in her room. The assessment revealed the resident required staff supervision with set up help only for eating and was always continent of her bladder and bowel.<br><br>A review of Resident #76's active care plans revealed the resident was admitted for a short term stay with the desire to return to the community and/or determination for long term stay not approved. Her care plans indicated she had impaired cognitive function/ dementia or impaired thought processes related to dementia and impaired decision making. Interventions indicated the resident needed assistance with all decision making.<br><br>A review of Resident #76's progress notes revealed a nurse's note dated 01/07/23 at 11:14 A.M. by Licensed Practical Nurse (LPN) #47 that indicated the resident's husband was noted to be in her room, by an unidentified employee of the activity department, and smelled like alcohol. The nurse informed the activity employee the husband was not allowed in the resident's room. The nurse and a trainer (LPN #190) went to the resident's room and saw the husband toileting the resident. The nurse informed the husband staff were to toilet and change the resident. The resident's husband became belligerent and told the nurse the only problem he had with the staff was her. The unit manager (LPN #79) informed the nurse to let the husband do care if he wanted to; he was permitted to be in the resident's room, but the door needed to be open.<br><br>On 01/25/23 at 10:06 A.M., an interview with LPN #47 revealed there was conversations over the weekend following Resident #76's admission about resident's husband being allowed in the room and providing care to the resident. A housekeeping supervisor was there providing her with the instructions that he was not to be in her room nor was he to provide care to her. The housekeeping supervisor was the weekend supervisor working that weekend and she had talked with someone in authority that was medically trained. She was not sure who that person may have been. She was also present when they received report from the hospital, and it was made known to them to watch Resident #76's husband. The hospital reported they had problems with him while the resident was in the hospital and the husband had been arrested. She reported the hospital had cameras in the room that showed the husband give Resident #76 medications and was also observed to be verbally/ physically abusive towards the resident while there. LPN #47 confirmed it was decided the husband was permitted in Resident #76's room if the door was open and could provide her with care. LPN #47 claimed her trainer was scolded by the facility's Admissions Director and was told since Resident #76 was married her husband had rights and could do whatever he wanted.<br><br>Further review of Resident #76's progress notes revealed additional documented incidents in which verbal/mental/physical/sexual abuse was indicated to have occurred or was suspected as having occurred. The incidents are as follows:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | a. A review of a nurse's progress note for Resident #76 dated 01/07/23 at 7:00 P.M. by LPN #55 revealed the nurse and the aides (nursing assistants) were standing in the dining area when they heard Resident #76 scream. The door to her room was open and the resident's husband had the resident on the toilet changing her clothes. The nurse and aides were in the hallway when the husband yelled at Resident #76 to keep her hands on her F****** head and not to touch anything. The nurse began to enter the room when the husband saw her reflection in the mirror. He then changed how he was talking to the resident and apologized. The documentation did not indicate the situation of verbal/mental abuse was reported to anyone in management.<br><br>On 01/25/23 at 1:25 P.M., an interview with LPN #55 revealed she did consider what she heard on 01/07/23 at 7:00 P.M. to be verbal/ mental abuse. She stated she reported the incident to the unit manager (LPN #250) who was on call at the time. The unit manager told her in response that was Resident #76's husband and he could talk to Resident #76 how he wanted to. LPN #55 was not sure if the unit manager reported the incident to the Director of Nursing (DON) or the facility Administrator. LPN #55 did not feel it was passed on to the upper management based on what the unit manager's response was to her.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she had worked at the facility for two months. The Administrator was asked about the incident that was documented in Resident #76's progress notes for 01/07/23 at 7:00 P.M. The Administrator stated that behavior from the husband was inappropriate, but she would not say it was verbal abuse. The Administrator was asked what she would consider to be verbal abuse and indicated screaming and yelling. The nurse's progress note was reviewed with the Administrator again and she confirmed that should have been considered verbal abuse. The Administrator denied the incident was reported to her but did confirm they had a unit manager by the first name (LPN #250) who was identified by LPN #55 as having reported the incident to. The Administrator reported alleged perpetrators in abuse allegations can be a resident's family member. Being married to someone did not exclude them from being able to abuse that person verbally or physically. The Administrator confirmed the unit manager should have made her of and the DON aware of the incident so it could have been reported and investigated.<br><br>b. A review of Resident #76's progress notes revealed a nurse's note by LPN #61 on 01/12/23 at 7:58 A.M. that indicated the nurse, and the aides were in the dining room area during breakfast and the morning medication pass. An unidentified aide came to the nurse and reported Resident #76's husband told the resident to straighten the F*** up and grabbed her hand throwing it down on the table. The aide also heard him asking Resident #76 to keep eating even though the resident said she was done. He then told Resident #76 to put the F****** food in her mouth and he started spooning the food into her mouth. The nurse indicated she heard the husband tell Resident #76 that she needed to stop being a F****** B**** and use her God D*** walker. The husband said all those things in a hushed tone and acted totally different and nice to Resident #76 when he noticed staff were watching him. A late entry note by LPN #61 dated 01/12/23 at 7:30 A.M. revealed the nurse assessed Resident #76 for injuries after the previous incident. No injuries were noted, and the resident did not show signs of distress at that time. The nurse redirected the husband and told him that he could not touch residents like that, regardless of whether they were their spouse or not.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/25/23 at 10:30 A.M., an interview with LPN #61 revealed she was not sure if what she witnessed on 01/12/23 was abuse or not. She stated it was not okay to do to someone that was not of sound mind. LPN #61 indicated she did report the incident to the DON and the DON came back to talk to her about her documentation. LPN #61 alleged the secured unit's unit manager (LPN #79) was there at the time she talked to the DON. The DON reviewed the nurse's note and told staff to intervene and redirect. Then and only then were they able to escort the husband off the property or to call the local law enforcement if he did not change his behavior. LPN #61 then said the DON told her they do not use the word abuse. LPN #61 felt the situation met the definition of verbal and physical abuse. LPN #61 felt the husband was willful in his intent and changed his tone when the staff were present.<br><br>On 01/25/23 at 12:02 P.M., an interview with LPN #79 revealed he was the unit manager for both the secured unit and the rehabilitation unit. He stated he was aware of the incident that occurred on 01/12/23 between Resident #76 and her husband. LPN #61 told him about it and he told the DON. LPN #79 confirmed the DON kept telling staff to redirect and if they felt the husband was a threat then they could call the local law enforcement. LPN #79 reported he would consider the incident that occurred on 01/12/23 between Resident #76 and her husband to be abuse. LPN #79 was not sure why that incident on 01/12/23 was not reported to the State agency or further investigated. LPN #79 denied he heard the DON tell LPN #61 they did not use the word abuse there.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she was not made aware of the incident that occurred with Resident #76 and her husband on 01/12/23 at 7:58 A.M. The Administrator had reviewed the note and indicated the staff intervened during that incident between the husband and Resident #76. The Administrator indicated Resident #76 did not show any signs of being in distress nor did she have any signs or symptoms of any injuries.<br><br>c. A review of the local law enforcement's report for a suspicion of sexual abuse on 01/21/23 involving Resident #76, as perpetrated by her husband, revealed the Sheriff's Deputy had interviewed LPN #88 about an incident that occurred that afternoon at 3:00 P.M. During LPN #88's interview, it was determined there had been other issues that had come up of a sexual nature between Resident #76 and her husband. The incident mentioned was indicated to have happened last night (01/20/23) and involved Resident #76's husband being caught lying in the resident's bed while naked. The statement provided by the nurse identified Medical Assistant #95 as the employee who witnessed that incident along with STNA 100. None of those prior incidents determined by staff had been reported to local law enforcement and staff had only documented them in the husband's visitors notes.<br><br>A review of Resident #76's progress notes revealed it was absent for any documentation of an incident occurring the night of 01/20/23. The last progress note written on 01/20/23 was a social service note at 4:42 P.M. The next note was the nurse's note that documented the incident on 01/21/23 at 3:00 P.M. when sexual abuse was suspected.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/25/23 at 12:27 P.M., an interview with LPN #88 confirmed she indicated in her statement to the local law enforcement when interviewed about the sexual abuse suspicion that occurred on 01/21/23 that there had been a prior incident the night before. LPN #88 had been told earlier that day by a night shift aide (STNA #100) (before the sexual abuse incident occurred on 01/21/23 at 3:00 P.M.) that Resident #76's husband had been in bed with the resident the previous night naked. After that, the husband was asked to leave. LPN #88 stated that incident had been reported (to unidentified management staff) and what was told to staff was that was her (Resident #76's) husband and she was allowed to have sex with him. LPN #88 was not sure who said that but the person who did was management staff. Medical Assistant #95 was the one who relayed the information to her and STNA #100 was also a witness to that incident. LPN #88 stated she would not consider Resident #76 to be one who could consent to sex, and anything done would not be consensual.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she did see in the local law enforcement report an incident was alleged to have occurred the night of 01/20/23. She confirmed it was reported Resident #76's husband was found in bed naked with her. The Administrator also confirmed there was no documentation in the progress notes to reflect an incident had occurred the night of 01/20/23. The Administrator denied they had a visitor's log for the resident's husband that would have recorded any notes. The Administrator stated she saw the same when reviewing the report and asked staff if there was such a thing and was told there was not. The Administrator denied being made aware of any inappropriate incidents that had occurred between Resident #76 and her husband on 01/20/23.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/25/23 at 2:58 P.M., an interview with Medical Assistant #95 confirmed he had witnessed an incident between Resident #76 and her husband the evening of 01/20/23. He stated he was on the unit to pass medications when STNA #100 asked him to stop by and tell Resident #76's husband what time it was and that visiting hours were going to be over. Medical Assistant #95 observed Resident #76's husband to be lying in bed with her without a shirt on and snuggling with the resident. Medical Assistant #95 could not see at that time if the husband was clothed from the waist down as he had a blanket over him. Medical Assistant #95's first thought was to provide them privacy, so he moved his cart across the hall to another resident's room. Medical Assistant #95 was still able to see into Resident #76's room and then observed the husband to get out of bed. Resident #76's husband exited the side of the bed closest to the window and furthest from the door. Medical Assistant #95 was able to see at that time the husband was completely naked. Medical Assistant #95 did not look close enough to see if the husband had an erection or not when he got out of the bed. Medical Assistant #95 reported Resident #76 was dressed in a gown, but he could not tell if she had a pull up incontinent brief on or not. Medical Assistant #95 was not concerned at that moment of abuse occurring. It was not until the resident began to cough that he felt abuse occurred. Resident #76's husband began to scream at the resident when she started coughing. He told the resident to shut the F*** up, you're being too loud. Resident #76 continued to cough, and the husband said, Oh my God, you are being so loud, why are you being so F****** loud. Medical Assistant #95 then recalled there had been many incidents with the husband. Medical Assistant #95 had seen the husband in his car with the window down as he was reporting to work and coming into the building. Medical Assistant #95 said the smoke reeked of marijuana and he saw the husband drinking beer. Medical Assistant #95 was not sure why the facility was allowing Resident #76's husband to come and go as he pleased. The husband even had the code to the secured unit to be able to enter and exit at will. Medical Assistant #95 felt what he witnessed of the husband screaming at the resident was abuse. Medical Assistant #95 indicated he informed the nurse (RN #550) who was on duty at the time but was not sure if she passed it along. Medical Assistant #95 stated that nurse was good about reporting things when needed. Medical Assistant #95 stated he told the nurse word for word what he had heard and saw.<br><br>d. A review of Resident #76's progress notes revealed a late entry nurse's note dated 01/22/23 at 11:55 A.M. by LPN #88. The late entry was for 01/21/23. The nurse indicated, upon entering Resident #76's room to complete a skin assessment following the incident that involved suspected sexual abuse on 01/21/23, a metal chained leash with a collar attached was seen on the resident's bedside table. The nurse indicated in her note, to the knowledge of the staff that were on duty, no dog had been brought to the facility by Resident #76's husband. It was removed from the room and secured at the nurse's station.<br><br>On 01/25/23 at 8:59 A.M., an interview with STNA #120 revealed Resident #76's husband was known to make gross sexual comments to the resident when he visited. STNA #120 reported having knowledge of Resident #76's husband having a dog chain with a collar on at one time. He placed the collar around his neck and had Resident #76 hold the metal chained leash part and acted like she was walking him around. He did that in the dining room on the secured unit in front of staff and other residents. STNA #120 recalled the husband making a comment for everyone to look at him saying I'm her B****. STNA #120 felt his behavior was inappropriate but did not report it as potential abuse.<br><br>(continued on next page) |

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| | 365394 | A. Building<br>B. Wing | 02/01/2023 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/25/23 at 12:02 P.M., an interview with LPN #79 revealed he was the unit manager for the secured unit. LPN #79 denied he had been made aware of any incident occurring with Resident #76's husband that involved a dog collar. LPN #79 saw the progress note that mentioned the dog collar but was not aware of it being used in a sexual manner. LPN #79 stated, if the leash and dog collar was used in the manner that STNA #120 described it to be, that would not be appropriate. LPN #79 stated if he had been made aware he would have shut that down and would have asked Resident #76's husband to leave. LPN #79 felt it would be humiliating and upsetting to the resident if that occurred. LPN #79 stated he was aware there were times the resident's husband would be in the building smelling of alcohol. LPN #79 stated Resident #76's husband admitted to drinking one or two beers before coming into the facility and smoking marijuana. If the husband was doing those things and was belligerent, he would ask him to leave or call local law enforcement. LPN #79 revealed he considered Resident #76's husband to be disruptive when there.<br><br>On 01/25/23 at 12:27 P.M., an interview with LPN #88 confirmed she wrote the late entry nurse's note on 01/22/23 at 11:55 A.M. about the leash and dog collar. When she asked the aides about that, STNA #120 had told her the husband put it on himself and had Resident #76 hold the leash part. The husband would then say see she's not my B****, I'm her B****. LPN #88 felt the incident with the dog collar was inappropriate. LPN #88 stated that behavior would be upsetting and humiliating using the reasonable person concept.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she had not been notified of there being any incident involving a leash and a dog collar. The Administrator stated if she would have been made aware of that incident, she would have made Resident #76's husband leave. The Administrator reported that type of behavior would be inappropriate in front of anyone. The Administrator then stated what people do at home was their own business but in a living community it was inappropriate. The Administrator indicated she could not say if the resident would have been humiliated or upset by the incident. The Administrator was then asked, if her husband had done that to her in front of others, would it be humiliating and upsetting to her. The Administrator replied that it would be.<br><br>e. A review of facility self-reported incident (SRI) tracking number 231321 dated 01/21/23 revealed an allegation of sexual abuse was made with a staff member being the initial source of the allegation/ suspicion. The alleged perpetrator was identified as being a family member/ visitor. The involved resident was indicated to be Resident #76, and the alleged perpetrator was her husband. The date and time of the occurrence was on 01/21/23 at 3:00 P.M. in the resident's room. The resident was noted to have dementia and was not able to provide any meaningful information wh [TRUNCATED] |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923<br><br>Based on record review, review of the local law enforcement's investigation into an incident of suspected sexual abuse related to self-reporting incident (SRI) #231321, staff interview, and policy review, the facility failed to ensure actual/ suspected/ or potential incidents of verbal, mental, physical and sexual abuse were reported to the Ohio Department of Health when they occurred. This affected one (#76) of one resident reviewed in one of one SRI. This had the potential to affect all residents residing in the facility. The facility's census was 103.<br><br>Findings included<br><br>A review of Resident #76's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included dementia and major depressive disorder. She was placed on the facility's secured dementia unit upon her admission.<br><br>A review of Resident #76's profile in the electronic health record (EHR) identified her spouse and her emergency contact #1. No other family members were identified as an emergency contact.<br><br>A review of Resident #76's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate hearing without the use of a hearing aid. Her vision was adequate without the use of any corrective lenses. Her speech was clear, and she was able to make herself understood and was able to understand others. Her cognition was indicated to be severely impaired. She was not known to display any behaviors, nor was she known to reject care during the seven days of her assessment period. She required an extensive assist of two for transfers. She required an extensive assist of one for locomotion on and off the unit, dressing and toilet use. She required a limited assist of one for ambulation in her room. She required supervision with set up help only for eating. She was always continent of her bladder and bowel.<br><br>A review of Resident #76's active care plans revealed she was short term stay with the desire to return to the community and/ or determination for long term stay was not approved. Her care plans indicated she had impaired cognitive function/ dementia or impaired thought processes related to dementia and impaired decision making. The interventions for that care plan indicated she needed assistance with all decision making.<br><br>A review of Resident #76's progress notes revealed a nurse's note dated 01/07/23 at 11:14 A.M. by LPN #47 that indicated the resident's husband was noted to be in her room by an employee of the activity department and smelled like alcohol. The nurse informed the activity employee that the husband was not allowed in the resident's room. The nurse and a trainer went to the resident's room and saw him toileting the resident. The nurse informed the husband that staff were to toilet and change the resident. The resident's husband became belligerent and told the nurse the only problem he had with the staff was her. The unit manager informed the nurse to let the husband do care if he wanted to. He was permitted to be in her room, but the door needed to be open.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 01/25/23 at 10:06 A.M., an interview with Licensed Practical Nurse (LPN) #47 revealed there was conversations over the weekend following Resident #76's admission about the husband being allowed in the room and providing care to the resident. A housekeeping supervisor was there providing her with the instructions that he was not to be in her room nor was he to provide care to her. The housekeeping supervisor was the weekend supervisor working that weekend and she had talked with someone in authority that was medically trained. She was not sure who that person may have been. She was also present when they received report from the hospital, and it was made known to them to watch Resident #76's husband. The hospital reported they had problems with him while the resident was in the hospital and the husband had been arrested. She reported the hospital had cameras in the room that showed the husband give her medications and was also observed to be verbally/ physically abusive towards the resident while there. She confirmed it was decided that the husband was permitted in the resident's room as long as the door was open and could provide her with care. She claimed her trainer was scolded by the facility's Admissions Director and was told since Resident #76 was married her husband had rights and could do whatever he wanted.<br><br>Further review of Resident #76's progress notes revealed three documented incidents in which verbal/ mental/ physical/ sexual abuse was indicated to have occurred or was suspected as having occurred. The facility's related investigation into the alleged sexual abuse for one of those three incidents identified two additional incidents in which sexual/ mental abuse potentially and/ or actually occurred. The four incidents are as followed:<br><br>1 a.) A review of a nurse's progress note for Resident #76 dated 01/07/23 at 7:00 P.M. by LPN #55 revealed the nurse and the aides (nursing assistants) were standing in the dining area when they heard Resident #76 scream. The door to her room was open and the husband had the resident on the toilet changing her clothes. The nurse and aides were in the hallway when the husband yelled at her to keep her hands on her F****** head and not to touch anything. The nurse began to enter the room when the husband saw her reflection in the mirror. He then changed how he was talking to the resident and apologized. The documentation did not indicate that the situation of verbal/ mental abuse was reported to anyone in management.<br><br>On 01/25/23 at 1:25 P.M., an interview with LPN #55 revealed she did consider what she heard on 01/07/23 at 7:00 P.M. to be verbal/ mental abuse. She stated she reported the incident to the unit manager who was on call at the time. The unit manager told her in response that was Resident #76's husband and he could talk to how he wanted to. She was not sure if the unit manager reported it to the Director of Nursing (DON) or the facility's Administrator. She did not feel it was passed on to the upper management based on what the unit manager's response was to her.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she had worked at the facility for two months now. She was asked about the incident that was documented in Resident #76's progress notes for 01/07/23 at 7:00 P.M. She stated that behavior from the husband was inappropriate, but she would not say it was verbal abuse. She was asked what she would consider to be verbal abuse and indicated screaming and yelling. The nurse's progress note was reviewed with her again and she confirmed that should have been considered verbal abuse. She denied that incident was reported to her but did confirm they had a unit manager by the first name that was identified by LPN #55 as having reported the incident to. She reported alleged perpetrators in abuse allegations can be a resident's family member. Being married to someone did not exclude them from being able to abuse that person verbally or physically. She confirmed the unit manager should have made her of the DON aware of the incident so it could have been investigated and reported to the state survey agency as required.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 1 b.) A review of Resident #76's progress notes revealed a nurse's note by LPN #61 on 01/12/23 at 7:58 A. M. that indicated the nurse, and the aides were in the dining room area during breakfast and the morning medication pass. An aide came to the nurse and reported Resident #76's husband told the resident to straighten the F*** up and grabbed her hand throwing it down on the table. The aide also heard him asking her to keep eating even though the resident said she was done. He then told her to put the F****** food in her mouth and started spooning the food into her mouth. The nurse indicated she heard the husband tell the resident that she needed to stop being a F****** B**** and use her God D*** walker. The husband said all those things in a hushed tone and acted totally different and nice to the resident when he noticed staff was watching him. A late entry note by LPN #61 dated 01/12/23 at 7:30 A.M. revealed the nurse assessed Resident #76 for injuries after the previous incident. No injuries were noted, and the resident did not show signs of distress at that time. The nurse redirected the husband and told him that they could not touch residents like that, regardless of whether they were their spouse or not.<br><br>On 01/25/23 at 10:30 A.M., an interview with LPN #61 revealed she was not sure if what she witnessed on 01/12/23 was abuse or not. She stated it was not okay to do to someone that was not of sound mind. She indicated she did report the incident to the DON and the DON came back to talk to her about her documentation. She alleged the secured unit's unit manager was there at the time she talked to the DON. The DON reviewed the nurse's note and told them to intervene and redirect. Then and only then were they able to escort the husband off the property or to call the local law enforcement if he did not change his behavior. She then said the DON told her they do not use the word abuse. She felt it met the definition of verbal and physical abuse. She felt the husband was willful in his intent and changed his tone when the staff were present.<br><br>On 01/25/23 at 12:02 P.M., an interview with LPN #79 revealed he was the unit manager for both the secured unit and the rehabilitation unit. He stated he was aware of the incident that occurred on 01/12/23 between Resident #76 and her husband. LPN #61 told him about it and he told the DON. He confirmed the DON kept telling them to redirect and if they felt the husband was a threat then they could call the local law enforcement. He reported he would consider the incident that occurred on 01/12/23 between Resident #76 and her husband to be abuse. He was not sure why that incident on 01/12/23 was not reported to the State agency or investigated. He denied that he heard the DON tell LPN #61 that they did not use the word abuse there.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she was not made aware of the incident that occurred with Resident #76 and her husband on 01/13/23 at 7:58 A.M. She had reviewed the note and indicated the staff intervened during that incident between the husband and the resident. She indicated the resident did not show any signs of being in distress nor did she have any signs or symptoms of any injuries. She revealed she did not consider that a situation in which a SRI was warranted and the incident was not reported as required.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 1 c.) A review of the local law enforcement's report for a suspicion of sexual abuse on 01/21/23 involving Resident #76, as perpetrated by her husband, revealed the Sheriff's Deputy had interviewed LPN #88 about the incident that occurred that afternoon at 3:00 P.M. During LPN #88's interview, it was determined that there had been other issues that had come up of a sexual nature between the resident and her husband. The incident mentioned was indicated to have happened last night (01/20/23) and involved her husband being caught lying in the resident's bed while naked. The statement provided by the nurse identified Medical Assistant #95 as the employee who witnessed that incident along with State tested Nursing Assistant (STNA) #100. None of those prior incidents discussed had been reported to local law enforcement and staff had only documented them in the husband's visitors notes.<br><br>A review of Resident #76's progress notes revealed it was absent for any documentation of an incident occurring the night of 01/20/23. The last progress note written on 01/20/23 was a social service note at 4:42 P.M. The next note what the nurse's note that documented the incident on 01/21/23 at 3:00 P.M. when sexual abuse was suspected.<br><br>On 01/25/23 at 12:27 P.M., an interview with LPN #88 confirmed she indicated in her statement to the local law enforcement when interviewed about the sexual abuse suspicion that occurred on 01/21/23 that there had been a prior incident the night before. She had been told earlier that day by a night shift aide (before the sexual abuse incident occurred on 01/21/23 at 3:00 P.M.) that Resident #76's husband had been in bed with the resident the previous night naked. After that, the husband was asked to leave. She stated that incident had been reported and what was told to them was that was her (Resident #76) husband and she was allowed to have sex with him. She was not sure who said that but the person that did was management staff. Medical Assistant #95 was the one that relayed that information to her and STNA #100 was also a witness to that incident. She would not consider Resident #76 to be one who could consent to sex, and anything done would not be consensual.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she did see in the local law enforcement's report that an incident was alleged to have occurred the night of 01/20/23. She confirmed it was reported that Resident #76's husband was found in bed naked with her. She also confirmed there was no documentation in the progress notes to reflect an incident had occurred the night of 01/20/23. She denied that they had a visitor's log for the resident's husband that would have recorded any notes. She stated she saw the same when reviewing the report and asked staff if there was such a thing and was told there was not. She denied being made aware of any inappropriate incident that had occurred between Resident #76 and her husband on 01/20/23.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 01/25/23 at 12:02 P.M., an interview with LPN #79 revealed he was the unit manager for the secured unit. He denied he had been made aware of any incident occurring with Resident #76's husband that involved a dog collar. He saw the progress note that mentioned the dog collar but was not aware of it being used in a sexual manner. He stated, if the leash and dog collar was used in the manner that STNA #120 described it to be, that would not be appropriate. He stated if he had been made aware he would have shut that down and would have asked him to leave. He felt it would be humiliating and upsetting to the resident if that occurred. He was aware there were times the resident's husband would be in the building smelling of alcohol. He stated the husband admitted to drinking one or two beers before coming into the facility and smoking marijuana. If the husband was doing those things and was belligerent, he would ask him to leave or call local law enforcement. He would consider the resident's husband to be disruptive when there.<br><br>On 01/25/23 at 12:27 P.M., an interview with LPN #88 confirmed she wrote the late entry nurse's note on 01/22/23 at 11:55 A.M. about the leash and dog collar. When she asked the aides about that, STNA #120 had told her the husband put it on himself and had Resident #76 hold the leash part. The husband would then say see she's not my B****, I'm her B****. She felt the incident with the dog collar was inappropriate. She stated that behavior would be upsetting and humiliating using the reasonable person concept.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she had not been notified of there being any incident involving a leash and a dog collar. She stated if she would have been made of that incident she would have made Resident #76's husband leave. She reported that type of behavior would be inappropriate in front of anyone. She then stated what people do at home was their own business but in a living community it was inappropriate. She indicated she could not say if the resident would have been humiliated or upset by that. She was then asked, if her husband had done that to her in front of others, would it be humiliating and upsetting to her. She replied that it would be. She denied they had any evidence of an SRI being submitted for any of these four incidents. The only SRI that had been submitted involving Resident #76 was SRI 231321 pertaining to the allegation of sexual abuse on 01/21/23.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A review of the facility's policy on Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property dated October 2022 revealed residents had the right to be free from abuse. It was the facility's policy to investigate all alleged violations involving abuse. Facility staff should immediately report all such allegations to the Administrator and to the Ohio Department of Health (ODH) in accordance with the procedures in that policy. In cases where a crime was suspected, the Administrator would report the same to the local law enforcement in accordance with the facility's crime reporting policy. Abuse was defined in the policy as being the willful infliction of injury with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse. An alleged violation was defined as a situation or occurrence that was observed or reported by staff, resident, relative visitor, or others but has not yet been investigated and, if verified, could be noncompliance with federal requirements related to mistreatment, exploitation, neglect, or abuse. Sexual abuse was defined as non-consensual sexual contact of any type with a resident. Criminal sexual abuse was serious bodily injury/ harm, shall be considered to have occurred if the conduct causing the injury constitutes aggravated sexual abuse or sexual abuse under federal law or any similar offense under state law e.g., it included sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others. It also included sexual intercourse with a resident who was incapable of declining to participate in the sexual act or lacked the ability to understand the nature of the sexual act. Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Under Prevention and Identification, the facility's procedures included establishing a safe environment that supported, to the extent possible, a resident's consensual sexual relationship, including a process for determining the resident's capacity to consent. Identifying, correcting, and intervening in situations in which abuse was more likely to occur in accordance with the facility's Quality Assurance and Performance Improvement Plan. They were also to ensure residents were safe from family members or representatives who visit in accordance with the facility's Visitation policy. Prevention and Identification also included ensuring staff knew how to identify abuse, including the types of abuse, and ensuring all staff were aware they needed to report all incidents and allegations of abuse. Under Protecting the Resident, staff should report all incidents/ allegations immediately to the Administrator or Designee. Under Ensuring Resident or Other Residents were protected, if a third party was accused or suspected (non-staff person e.g., visitor, family member etc.) was accused or suspected, the facility would take action to protect the resident in including, but not limited to, contacting the third party, and addressing the issue directly with him/ her, preventing access to the resident during the investigation, removing them from the premises, and/ or referring the matter to the appropriate authorities. Under Initial Report, all incidents and allegations of abuse must be reported immediately to the Administrator/ designee. If abuse was alleged, the Administrator or his/ her designee would notify ODH immediately, but no later than two hours after the allegation was made.<br><br>This deficiency is cited as an incidental finding to Complaint Number OH00139646. |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923<br><br>Based on record review, review of a local law enforcement investigation into an incident of suspected sexual abuse related to facility self-reporting incident (SRI) tracking number 231321, staff interview, and review of the facility Abuse policy and procedure, the facility failed to ensure actual, suspected, or potential incidents of verbal, mental, physical and sexual abuse were timely identified, reported, and investigated when they occurred to Resident #76, a cognitively impaired resident who resided on the facility secured memory care unit. Between 01/02/23 and 01/21/23, facility staff identified and/or observed incidents of interactions reflective of abuse towards Resident #76 by her husband, while he was visiting in the facility. This resulted in Immediate Jeopardy on 01/07/23, after Resident #76's husband was observed to be verbally/ mentally abusive to the resident while he was assisting her with personal care with no immediate protection of the resident, investigation of the incident or report of the incident to the State agency. Additional incidents reflective of actual/suspected/potential abuse occurred (after the initial incident of abuse by the husband) that were either not reported and/or not investigated by the facility. As a result, the facility failed to timely implement effective interventions to prevent those incidents of abuse from occurring and allowed Resident #76's husband to continue to visit the resident unsupervised until 01/21/23 at which time an alleged incident of sexual abuse occurred and the police were called. The lack of timely identification, reporting and investigation of incidents of abuse placed Resident #76 and all 103 facility residents at risk for actual/potential physical, emotional, psychosocial harm. The facility's census was 103.<br><br>On 01/26/23 at 10:36 A.M. the Administrator was notified Immediate Jeopardy began on 01/07/23 when Resident #76 was observed to be verbally and mentally abused by her husband while he was visiting in the facility and initial reporting of the abuse was not made to the Administrator resulting in no investigation being completed. Resident #76 endured additional incidents of actual/suspected/potential abuse at the hands of her husband with no protection, effective intervention, reporting or investigation from the facility to prevent further abuse from occurring until 01/21/23 following an alleged incident of suspected sexual abuse when the police were contacted and Resident #76's husband was restricted from visiting at the direction of local law enforcement pending a criminal investigation.<br><br>The Immediate Jeopardy was removed on 01/26/23 when the facility implemented the following corrective actions:<br><br>On 01/21/23 at 3:00 P.M. State tested Nursing Assistant (STNA) #120 witnessed an incident between Resident #76 and her husband. STNA #120 told the resident's husband to leave and Licensed Practical Nurse (LPN) #88 called the local sheriff's department. At 3:30 P.M. the Muskingum County Sheriff Department arrived at the facility and interviewed the LPN #88, two STNAs, Resident #76, and Resident #76's husband and removed him from the facility.<br><br>On 01/21/23 at 4:00 P.M. the Director of Nursing and Administrator were notified by LPN #79 of the incident by phone.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 01/21/23 at 4:15 P.M. the LPN #88 completed the skin assessment on Resident #76 and relayed the findings to the Nurse Practitioner (NP) #400, who gave the order to be sent to the emergency room (ER) for evaluation. The resident returned to the facility on [DATE] at 1:09 A.M. in stable condition.<br><br>On 01/23/23 at 10:30 A.M. the Administrator met with a detective from the Muskingum County Sheriff's Department and went over the incident with him. The detective took pictures of the room and spoke with Resident #76. Also, at this time a dog leash was retrieved from Resident #76 dresser drawer and given to the detective. The detective stated he would keep in contact with the Administrator as to what the next steps for the case would be.<br><br>On 01/24/23, at 9:30 A.M. the Administrator spoke with the detective from the Muskingum County Sheriff's department. The detective stated Resident #76's husband had been instructed that if he arrived on the premises of the facility he would be arrested.<br><br>On 01/24/23 at 10:00 A.M. one on one education for staff present and via phone call for staff not present was provided related to the facility abuse policy, which included what abuse was and reporting requirements was initiated by the DON/Designee and the Human Resource Director for all 117 staff members which included eight RNs, 22 LPNs, three Medical Assistants, 23, STNAs, one Activity Director, three Activity Aides, one Physical Therapist, one Occupational Therapist, three Speech Therapists, two COTAs, three PTAs, one Dietary Supervisor, one Dietary Manager, four Dietary Aides, 14 Cooks, one Human Resource Manager, one Medical Records Manager, one Central Supply/EVS Supervisor, two Receptionists, two Resident Assessment Coordinators, one Social Service Designee, one Admissions Director, one Transportation Coordinator, seven Housekeepers, five Laundry Staff, and three Maintenance staff. A plan for any staff member not educated to not work until education was completed was implemented.<br><br>On 01/25/23 at 11:03 A.M. Social Service Designee #200 spoke with Resident #76's husband and informed him Resident #76 would not be discharging from the facility (the resident had initially been admitted for short term rehabilitation).<br><br>On 01/25/23 at 1:30 P.M. the Administrator received a statement from the Medical Assistant #95 regarding an incident (alleged sexual abuse) that occurred on 01/20/23 with Resident #76 and her husband. The Administrator initiated an investigation on 01/25/23 at 1:30 P.M. and an initial SRI was submitted to the State agency on 01/26/23.<br><br>On 01/25/23 at 3:15 P.M. it was discovered that other alleged incidents of abuse occurred on 01/07/23, 01/12/23, unknown date, and 01/20/23. This information was given to the Administrator by the surveyor as discovered during the onsite complaint investigation. The Administrator started an investigation on 01/26/23 at 11:06 A.M. and submitted an initial SRI on 01/26/23.<br><br>On 01/25/23 at 3:38 P.M. Social Service Designee #200 spoke with the Ombudsman regarding emergency guardianship for Resident #76. The Ombudsman gave Social Service Designee #200 information. SSD #200 made a call to the county Social Worker (SW) who does guardianships and message left.<br><br>On 01/25/23 at 4:00 P.M. the facility Medical Director completed an expert evaluation for Resident #76 and deemed that she was incompetent. This information will assist in establishing guardianship for the resident.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 01/25/23 at 4:28 P.M. SRI with tracking number 231321 for the incident related to the 01/21/23 incident involving Resident #76 was completed and submitted to the State agency by the Administrator.<br><br>On 01/26/23 at 10:15 A.M. the Administrator interviewed STNA #120 by phone regarding an incident involving a collar and leash that happened a week or so ago. This alleged incident was never reported and there was no documentation to support the incident in Resident #76 medical record.<br><br>On 01/26/23 at 10:40 A.M. interviews were started by Management staff comprised of the Activity Director, Central Supply Manager, Medical Records Director, Social Service Designee, Admissions Director, and Activity Assistant for 46 residents with a Brief Interview for Mental Status (BIMS) score greater than 13 using the facility Resident Abuse Questionnaire with questions consisting of: Has anyone made you feel afraid or humiliated degraded, said mean things to you, hurt you, made you feel uncomfortable? Have you seen or heard of any residents being treated in any of these ways? If so, did you tell anyone about what happened? No new concerns were identified by the facility following these interviews.<br><br>On 01/26/23 at 10:40 A.M. education was started by the Human Resource Manager to all staff regarding the fact Resident #76's husband was not permitted at the facility and facility visitation policy, which included restricting visitation if a visitor was intoxicated and/or belligerent. As of 01/26/23 at 117 staff members had completed the education. The facility implemented a plan that any staff member who had not been educated would be educated prior to their next worked shift.<br><br>On 01/26/23 at 10:50 A.M. a Facility Quality Assessment and Assurance Committee ADHOC meeting was held by phone with the Facility Medical Director, Administrator, and RN, and Certus Clinical Support Nurse #415 regarding incidents of abuse involving Resident #76 which occurred on 01/07/23, 01/12/23, an unknown date, 01/20/23, and 01/21/23 and what corrective action measures were being taken.<br><br>On 01/26/23 at 11:00 A.M. RN, Certus Clinical Support Nurse #420 completed re-education regarding the facility abuse policy, including reporting and that even spouses could be abusers. Education was also provided related to the facility visitation policy that included restricting visitation to anyone who was intoxicated and/or belligerent with the Administrator, Director of Nursing via phone, LPN Unit Manager for halls 500, 600, and 700 and LPN Unit Manager for halls 100, 200, and secured unit.<br><br>On 01/26/23 at 11:06 A.M. the Administrator received a statement from STNA #120 on the secured unit regarding an incident on an unknown date when Resident #76's husband had a collar around his neck with Resident #76.<br><br>On 01/26/23 from 11:15 A.M. to 12:24 P.M. skin inspections were performed by LPN #250 Unit Manager for 500, 600, 700 halls and LPN Unit Manager 100, 200, and secured unit for 45 residents with a BIMS score less than 13. No abnormalities were found by the staff completing the inspections.<br><br>On 01/26/23 at 12:30 P.M. Administrator, spoke with Social Worker regarding emergency guardianship of Resident #76. Social Worker emailed a Supplement for Emergency Guardian of Person to Administrator for Medical Director to complete. Medical Director completed at 1:15 P.M.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 01/26/23 at 1:00 P.M. RN Clinical Support Nurse #415 and Transportation Coordinator initiated employee interviews related to staff witnessing abuse or potential abuse for all staff. A plan for any staff not interviewed during this time to be interviewed prior to their next scheduled shift was implemented following the interviews.<br><br>On 01/26/23 at 2:37 P.M. the Administrator emailed the Social Worker a signed service agreement and the completed supplement for emergency guardian of person forms for Resident #76.<br><br>On 01/26/23 at 2:46 P.M. Administrator submitted an initial SRI for incidents that were found to have occurred on 01/07/23, 01/12/23, unknown date, and 01/20/23 involving Resident #76.<br><br>On 01/26/23 at 3:10 P.M. RN, Certus Clinical Support Nurse completed an audit of 37 residents with frequent visitors. Of the list, none were identified as potential resident abusers or ones who could cause harm.<br><br>On 01/27/23 at 2:16 P.M. emergency guardianship was granted by the Probate Court of Muskingum County for Resident #76.<br><br>Beginning 01/27/23, during the morning interdisciplinary team (IDT) meeting the facility would discuss if any new allegations or concerns of abuse had been brought to anyone staff members attention as well as reviewing 24-hour report. The facility indicated any/all allegations would be thoroughly investigated, and actions would be taken to ensure the facility was following the abuse policy. The facility identified the deficient practice occurred related to a failure to address and report suspicious behavior of Resident #76's husband per facility abuse policy.<br><br>Beginning 01/30/23 the Director of Nursing or her designee would conduct an audit of 10 employees using the Staff Abuse questionnaire. The audit would be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality Assurance and Performance Committee for ongoing compliance.<br><br>Beginning 01/30/23 the Director of Nursing or her designee would conduct an audit of 10 residents using the Resident Abuse Interview Tool and the skin assessment. The audit would be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality assurance and Performance Committee for ongoing compliance.<br><br>On 01/30/23 from 9:01 A.M. to 9:28 A.M. interviews were conducted by the surveyor with one housekeeper, three STNAs, and two LPNs to confirm they received training on the facility's abuse and visitation policy. All staff interviewed confirmed receiving the training and exhibited an understanding of the training received.<br><br>Although the Immediate Jeopardy was removed on 01/26/23, the facility remained 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 actions and monitoring to ensure on-going compliance.<br><br>Findings Include:<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | A review of Resident #76's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia and major depressive disorder. the resident was admitted to the facility secured dementia unit at the time of her admission.<br><br>A review of Resident #76's profile in the electronic health record (EHR) identified her spouse as her emergency contact #1. No other family members were identified as an emergency contact.<br><br>A review of Resident #76's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had adequate hearing without the use of a hearing aid. Her vision was adequate without the use of any corrective lenses. Her speech was clear, and she was able to make herself understood and was able to understand others. The assessment noted the resident had severely impaired cognition. She was not known to display any behaviors, nor was she known to reject care during the seven days of her assessment period. The assessment revealed the resident required extensive assist from two staff for transfers, extensive assist from one staff for locomotion on and off the unit, dressing and toilet use and limited assistance from one staff for ambulation in her room. The assessment revealed the resident required staff supervision with set up help only for eating and was always continent of her bladder and bowel.<br><br>A review of Resident #76's active care plans revealed the resident was admitted for a short term stay with the desire to return to the community and/or determination for long term stay not approved. Her care plans indicated she had impaired cognitive function/ dementia or impaired thought processes related to dementia and impaired decision making. Interventions indicated the resident needed assistance with all decision making.<br><br>A review of Resident #76's progress notes revealed a nurse's note dated 01/07/23 at 11:14 A.M. by Licensed Practical Nurse (LPN) #47 that indicated the resident's husband was noted to be in her room, by an unidentified employee of the activity department, and smelled like alcohol. The nurse informed the activity employee the husband was not allowed in the resident's room. The nurse and a trainer (LPN #190) went to the resident's room and saw the husband toileting the resident. The nurse informed the husband staff were to toilet and change the resident. The resident's husband became belligerent and told the nurse the only problem he had with the staff was her. The unit manager (LPN #79) informed the nurse to let the husband do care if he wanted to; he was permitted to be in the resident's room, but the door needed to be open.<br><br>On 01/25/23 at 10:06 A.M., an interview with LPN #47 revealed there was conversations over the weekend following Resident #76's admission about resident's husband being allowed in the room and providing care to the resident. A housekeeping supervisor was there providing her with the instructions that he was not to be in her room nor was he to provide care to her. The housekeeping supervisor was the weekend supervisor working that weekend and she had talked with someone in authority that was medically trained. She was not sure who that person may have been. She was also present when they received report from the hospital, and it was made known to them to watch Resident #76's husband. The hospital reported they had problems with him while the resident was in the hospital and the husband had been arrested. She reported the hospital had cameras in the room that showed the husband give Resident #76 medications and was also observed to be verbally/ physically abusive towards the resident while there. LPN #47 confirmed it was decided the husband was permitted in Resident #76's room if the door was open and could provide her with care. LPN #47 claimed her trainer was scolded by the facility's Admissions Director and was told since Resident #76 was married her husband had rights and could do whatever he wanted.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Further review of Resident #76's progress notes revealed additional documented incidents in which verbal/mental/physical/sexual abuse was indicated to have occurred or was suspected as having occurred. The incidents are as follows:<br><br>a. A review of a nurse's progress note for Resident #76 dated 01/07/23 at 7:00 P.M. by LPN #55 revealed the nurse and the aides (nursing assistants) were standing in the dining area when they heard Resident #76 scream. The door to her room was open and the husband had the resident on the toilet changing her clothes. The nurse and aides were in the hallway when the husband yelled at her to keep her hands on her F****** head and not to touch anything. The nurse began to enter the room when the husband saw her reflection in the mirror. He then changed how he was talking to the resident and apologized. The documentation did not indicate that the situation of verbal/ mental abuse was reported to anyone in management.<br><br>On 01/25/23 at 1:25 P.M., an interview with LPN #55 revealed she did consider what she heard on 01/07/23 at 7:00 P.M. to be verbal/ mental abuse. She stated she reported the incident to the unit manager who was on call at the time. The unit manager told her in response that was Resident #76's husband and he could talk to how he wanted to. She was not sure if the unit manager reported it to the Director of Nursing (DON) or the facility Administrator. She did not feel it was passed on to the upper management based on what the unit manager's response was to her.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she had worked at the facility for two months as the Administrator. She was asked about the incident that was documented in Resident #76's progress notes for 01/07/23 at 7:00 P.M. The Administrator stated that behavior from the husband was inappropriate, but she would not say it was verbal abuse. The Administrator was asked what she would consider to be verbal abuse and indicated screaming and yelling. The nurse's progress note was reviewed with Administrator again and she confirmed the incident should have been considered verbal abuse. She denied that incident was reported to her but did confirm they had a unit manager by the first name (LPN #250) who was identified by LPN #55 as having reported the incident to. She reported alleged perpetrators in abuse allegations can be a resident's family member. Being married to someone did not exclude them from being able to abuse that person verbally or physically. She confirmed the unit manager should have made her and the DON aware of the incident so it could have been reported and investigated.<br><br>b. A review of Resident #76's progress notes revealed a nurse's note by LPN #61 on 01/12/23 at 7:58 A.M. that indicated the nurse, and the aides were in the dining room area during breakfast and the morning medication pass. An aide came to the nurse and reported Resident #76's husband told the resident to straighten the F*** up and grabbed her hand throwing it down on the table. The aide also heard him asking her to keep eating even though the resident said she was done. He then told her to put the F****** food in her mouth and started spooning the food into her mouth. The nurse indicated she heard the husband tell the resident that she needed to stop being a F****** B**** and use her God D*** walker. The husband said all those things in a hushed tone and acted totally different and nice to the resident when he noticed staff were watching him. A late entry note, by LPN #61 dated 01/12/23 at 7:30 A.M. revealed the nurse assessed Resident #76 for injuries after the previous incident. No injuries were noted, and the resident did not show signs of distress at that time. The nurse redirected the husband and told him that he could not touch residents like that, regardless of whether they were their spouse or not.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 01/25/23 at 10:30 A.M., an interview with LPN #61 revealed she was not sure if what she witnessed on 01/12/23 was abuse or not. She stated it was not okay to do to someone that was not of sound mind. She indicated she did report the incident to the DON and the DON came back to talk to her about her documentation. She alleged the secured unit manager was there at the time she talked to the DON. The DON reviewed the nurse's note and told them to intervene and redirect. Then and only then were they able to escort the husband off the property or to call the local law enforcement if he did not change his behavior. She then said the DON told her they do not use the word abuse. She felt it met the definition of verbal and physical abuse. She felt the husband was willful in his intent and changed his tone when the staff were present.<br><br>On 01/25/23 at 12:02 P.M., an interview with LPN #79 revealed he was the unit manager for both the secured unit and the rehabilitation unit. He stated he was aware of the incident that occurred on 01/12/23 between Resident #76 and her husband. LPN #61 told him about it, and he told the DON. He confirmed the DON kept telling staff to redirect and if they felt the husband was a threat then they could call the local law enforcement. He reported he would consider the incident that occurred on 01/12/23 between Resident #76 and her husband to be abuse. He was not sure why that incident on 01/12/23 was not reported to the State agency or investigated. He denied that he heard the DON tell LPN #61 that they did not use the word abuse there.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she was not made aware of the incident that occurred with Resident #76 and her husband on 01/12/23 at 7:58 A.M. She had reviewed the note and indicated the staff intervened during that incident between the husband and the resident. She indicated the resident did not show any signs of being in distress nor did she have any signs or symptoms of any injuries. She revealed she did not consider the incident a situation in which an SRI was warranted.<br><br>c. A review of the local law enforcement's report for a suspicion of sexual abuse on 01/21/23 involving Resident #76, as perpetrated by her husband, revealed the sheriff's deputy had interviewed LPN #88 about the incident that occurred that afternoon at 3:00 P.M. During LPN #88's interview, it was determined there had been other issues that had come up of a sexual nature between the resident and her husband. The report noted an incident that had happened last night (01/20/23) and involved Resident #76's husband being caught lying in the resident's bed while naked. The statement provided by the nurse identified Medical Assistant #95 as the employee who witnessed that incident along with State tested Nursing Assistant #100. None of the prior incidents discussed had been reported to local law enforcement and staff had only documented them in the husband's visitors notes.<br><br>A review of Resident #76's progress notes revealed it was absent for any documentation of an incident occurring the night of 01/20/23. The last progress note written on 01/20/23 was a social service note at 4:42 P.M. The next note what the nurse's note that documented the incident on 01/21/23 at 3:00 P.M. when sexual abuse was suspected.<br><br>(continued on next page) |

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| | 365394 | A. Building<br>B. Wing | 02/01/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Continuing Healthcare at Adams Lane | 1856 Adams Lane<br>Zanesville, OH 43701 |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 01/25/23 at 12:27 P.M., an interview with LPN #88 confirmed she indicated in her statement to the local law enforcement when interviewed about the sexual abuse suspicion that occurred on 01/21/23 that there had been a prior incident the night before. She had been told earlier that day by a night shift aide (before the sexual abuse incident occurred on 01/21/23 at 3:00 P.M.) that Resident #76's husband had been in bed with the resident the previous night naked. After that, the husband was asked to leave. She stated that incident had been reported and what was told to staff was that was her (Resident #76's) husband and she was allowed to have sex with him. She was not sure who said that but the person that did was management staff. Medical Assistant #95 was the one who relayed the information to her and STNA #100 was also a witness to that incident. She would not consider Resident #76 to be one who could consent to sex, and anything done would not be consensual.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she did see in the local law enforcement's report that an incident was alleged to have occurred the night of 01/20/23. She confirmed it was reported Resident #76's husband was found in bed naked with her. She also confirmed there was no documentation in the progress notes to reflect an incident had occurred the night of 01/20/23. She denied they had a visitor's log for the resident's husband that would have recorded any notes. She stated she saw the same when reviewing the report and asked staff if there was such a thing and was told there was not. She denied being made aware of any inappropriate incidents that had occurred between Resident #76 and her husband on 01/20/23.<br><br>On 01/25/23 at 2:58 P.M., an interview with Medical Assistant #95 confirmed he had witnessed an incident between Resident #76 and her husband the evening of 01/20/23. He stated he was on the unit to pass medications when STNA #100 asked him to stop by and tell Resident #76 what time it was and that visiting hours were going to be over. He observed Resident #76's husband to be lying in bed with her without a shirt on and snuggling with the resident. He could not see at that time if the husband was clothed from the waist down as he had a blanket over him. His first thought was to provide them privacy, so he moved his cart across the hall to another resident's room. He was still able to see into Resident #76's room and then observed the husband to get out of bed. He exited the side of the bed closest to the window and furthest from the door. He was able to see at that time the husband was completely naked. He did not look close enough to see if the husband had an erection or not when he got out of the bed. He reported the resident was dressed in a gown, but he could not tell if she had a pull up incontinent brief on or not. He was not concerned at that moment of abuse occurring. It was not until the resident began to cough that he felt abuse occurred. The husband began to scream at the resident when she started coughing. He told her to shut the F*** up, you're being too loud. She continued to cough, and the husband said, Oh my God, you are being so loud, why are you being so F****** loud. He recalled there had been many incidents with the husband. He had seen the husband in his car with the window down as he was reporting to work and coming into the building. He said the smoke reeked of marijuana and he saw the husband drinking beer. He was not sure why the facility was allowing him to come and go as he pleased. The husband even had the code to the secured unit to be able to enter and exit at will. He felt what he witnessed of the husband screaming at the resident was abuse. He indicated he informed the nurse (RN #550) that was on duty at the time but was not sure if she passed it along. He stated that nurse was good about reporting things when needed. He stated he told the nurse word for word what he had heard and saw.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | d. A review of Resident #76's progress notes revealed a late entry nurse's note dated 01/22/23 at 11:55 A.M. by LPN #88. The late entry was for 01/21/23. The nurse indicated, upon entering Resident #76's room to complete a skin assessment following the incident that involved suspected sexual abuse on 01/21/23, a metal chained leash with a collar attached was seen on the resident's bedside table. The nurse indicated in her note, to the knowledge of the staff that were on duty, no dog had been brought to the facility by the resident's husband. It was removed from the room and secured at the nurse's station.<br><br>On 01/25/23 at 8:59 A.M., an interview with STNA #120 revealed Resident #76's husband was known to make gross sexual comments to the resident when he visited. She reported having knowledge of him having a dog chain with a collar on at one time. He placed the collar around his neck and had the resident hold the metal chained leash part and acted like she was walking him around. He did that in the dining room on the secured unit in front of staff and other residents. She recalled him making a comment for everyone to look at him saying I'm her B****. She felt his behavior was inappropriate but did not report it as potential abuse.<br><br>On 01/25/23 at 12:02 P.M., an interview with LPN #79 revealed he was the unit manager for the secured unit. He denied he had been made aware of any incident occurring with Resident #76's husband that involved a dog collar. He saw the progress note that mentioned the dog collar but was not aware of it being used in a sexual manner. He stated, if the leash and dog collar was used in the manner that STNA #120 described it to be, that would not be appropriate. He stated if he had been made aware he would have shut that down and would have asked him to leave. He felt it would be humiliating and upsetting to the resident if that occurred. He was aware there were times the resident's husband would be in the building smelling of alcohol. He stated the husband admitted to drinking one or two beers before coming into the facility and smoking marijuana. If the husband was doing those things and was belligerent, he would ask him to leave or call local law enforcement. He would consider the resident's husband to be disruptive when there.<br><br>On 01/25/23 at 12:27 P.M., an interview with LPN #88 confirmed she wrote the late entry nurse's note on 01/22/23 at 11:55 A.M. about the leash and dog collar. When she asked the aides about that, STNA #120 had told her the husband put it on himself and had Resident #76 hold the leash part. The husband would then say see she's not my B****, I'm her B****. She felt the incident with the dog collar was inappropriate. She stated that behavior would be upsetting and humiliating using the reasonable person concept.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she had not been notified of there being any incident involving a leash and a dog collar. She stated if she would have been made of that incident, she would have made Resident #76's husband leave. She reported that type of behavior would be inappropriate in front of anyone. She then stated what people do at home was their own business but in a living community it was inappropriate. She indicated she could not say if the resident would have been humiliated or upset by that. She was then asked, if her husband had done that to her in front of others, would it be humiliating and upsetting to her. She replied that it would be.<br><br>A review of the facility policy on Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property dated October 2022 revealed residents had the right to be free from abuse. It was the facility policy to investigate all alleged violations involving abuse. Facility staff should immediately report all such allegations to the Administrator [TRUNCATED] |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923<br><br>Based on record review, facility policy and procedure review and interview the facility failed to be administered in a manner that allowed all residents to reach their highest practical well-being when the Administrator did not promptly identify situations of abuse and staff failed to immediately report actual/potential situations of abuse consistent with the facility abuse policy and procedure. This affected one (#76) of one resident reviewed for abuse but had the potential to affect all residents in the facility. The facility's census was 103.<br><br>Findings include:<br><br>A review of Resident #76's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included dementia and major depressive disorder. Her profile under the electronic health record (EHR) identified her husband as her only emergency contact.<br><br>A review of Resident #76's active care plans revealed the resident was admitted for a short term stay with the desire to return to the community and/or determination for long term stay not approved. Her care plans indicated she had impaired cognitive function/ dementia or impaired thought processes related to dementia and impaired decision making. Interventions indicated the resident needed assistance with all decision making.<br><br>A review of Resident #76's progress notes revealed a nurse's note dated 01/07/23 at 11:14 A.M. by Licensed Practical Nurse (LPN) #47 that indicated the resident's husband was noted to be in her room, by an unidentified employee of the activity department, and smelled like alcohol. The nurse informed the activity employee the husband was not allowed in the resident's room. The nurse and a trainer (LPN #190) went to the resident's room and saw the husband toileting the resident. The nurse informed the husband staff were to toilet and change the resident. The resident's husband became belligerent and told the nurse the only problem he had with the staff was her. The unit manager (LPN #79) informed the nurse to let the husband do care if he wanted to; he was permitted to be in the resident's room, but the door needed to be open.<br><br>Further review of Resident #76's progress notes revealed additional documented incidents in which verbal/mental/physical/sexual abuse was indicated to have occurred or was suspected as having occurred. The incidents are as follows:<br><br>a. A review of a nurse's progress note for Resident #76 dated 01/07/23 at 7:00 P.M. by LPN #55 revealed the nurse and the aides (nursing assistants) were standing in the dining area when they heard Resident #76 scream. The door to her room was open and the resident's husband had the resident on the toilet changing her clothes. The nurse and aides were in the hallway when the husband yelled at Resident #76 to keep her hands on her F****** head and not to touch anything. The nurse began to enter the room when the husband saw her reflection in the mirror. He then changed how he was talking to the resident and apologized. The documentation did not indicate the situation of verbal/mental abuse was reported to anyone in management.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she had worked at the facility for two months. The Administrator was asked about the incident that was documented in Resident #76's progress notes for 01/07/23 at 7:00 P.M. The Administrator stated that behavior from the husband was inappropriate, but she would not say it was verbal abuse. The Administrator was asked what she would consider to be verbal abuse and indicated screaming and yelling. The nurse's progress note was reviewed with the Administrator again and she confirmed that should have been considered verbal abuse. The Administrator denied the incident was reported to her but did confirm they had a unit manager by the first name (LPN #250) who was identified by LPN #55 as having reported the incident to. The Administrator reported alleged perpetrators in abuse allegations can be a resident's family member. Being married to someone did not exclude them from being able to abuse that person verbally or physically. The Administrator confirmed the unit manager should have made her of and the DON aware of the incident so it could have been reported and investigated.<br><br>b. A review of Resident #76's progress notes revealed a nurse's note by LPN #61 on 01/12/23 at 7:58 A.M. that indicated the nurse, and the aides were in the dining room area during breakfast and the morning medication pass. An unidentified aide came to the nurse and reported Resident #76's husband told the resident to straighten the F*** up and grabbed her hand throwing it down on the table. The aide also heard him asking Resident #76 to keep eating even though the resident said she was done. He then told Resident #76 to put the F****** food in her mouth and he started spooning the food into her mouth. The nurse indicated she heard the husband tell Resident #76 that she needed to stop being a F****** B**** and use her God D*** walker. The husband said all those things in a hushed tone and acted totally different and nice to Resident #76 when he noticed staff were watching him.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she was not made aware of the incident that occurred with Resident #76 and her husband on 01/12/23 at 7:58 A.M. The Administrator had reviewed the note and indicated the staff intervened during that incident between the husband and Resident #76. The Administrator indicated Resident #76 did not show any signs of being in distress nor did she have any signs or symptoms of any injuries. She did not view that incident to be a reportable event since the staff intervened and the resident showed no effect from the incident.<br><br>c. A review of the local law enforcement's report for a suspicion of sexual abuse on 01/21/23 involving Resident #76, as perpetrated by her husband, revealed the Sheriff's Deputy had interviewed LPN #88 about an incident that occurred that afternoon at 3:00 P.M. During LPN #88's interview, it was determined there had been other issues that had come up of a sexual nature between Resident #76 and her husband. The incident mentioned was indicated to have happened last night (01/20/23) and involved Resident #76's husband being caught lying in the resident's bed while naked. The statement provided by the nurse identified Medical Assistant #95 as the employee who witnessed that incident along with STNA 100. None of those prior incidents determined by staff had been reported to local law enforcement and staff had only documented them in the husband's visitors notes.<br><br>A review of Resident #76's progress notes revealed it was absent for any documentation of an incident occurring the night of 01/20/23.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she did see in the local law enforcement report an incident was alleged to have occurred the night of 01/20/23. She confirmed it was reported Resident #76's husband was found in bed naked with her. The Administrator also confirmed there was no documentation in the progress notes to reflect an incident had occurred the night of 01/20/23. The Administrator denied they had a visitor's log for the resident's husband that would have recorded any notes. The Administrator stated she saw the same when reviewing the report and asked staff if there was such a thing and was told there was not. The Administrator denied being made aware of any inappropriate incidents that had occurred between Resident #76 and her husband on 01/20/23.<br><br>d. A review of Resident #76's progress notes revealed a late entry nurse's note dated 01/22/23 at 11:55 A.M. by LPN #88. The late entry was for 01/21/23. The nurse indicated, upon entering Resident #76's room to complete a skin assessment following the incident that involved suspected sexual abuse on 01/21/23, a metal chained leash with a collar attached was seen on the resident's bedside table. The nurse indicated in her note, to the knowledge of the staff that were on duty, no dog had been brought to the facility by Resident #76's husband. It was removed from the room and secured at the nurse's station.<br><br>On 01/25/23 at 8:59 A.M., an interview with STNA #120 revealed Resident #76's husband was known to make gross sexual comments to the resident when he visited. STNA #120 reported having knowledge of Resident #76's husband having a dog chain with a collar on at one time. He placed the collar around his neck and had Resident #76 hold the metal chained leash part and acted like she was walking him around. He did that in the dining room on the secured unit in front of staff and other residents. STNA #120 recalled the husband making a comment for everyone to look at him saying I'm her B****. STNA #120 felt his behavior was inappropriate but did not report it as potential abuse.<br><br>On 01/25/23 at 2:13 P.M., an interview with the Administrator revealed she had not been notified of there being any incident involving a leash and a dog collar. The Administrator stated if she would have been made aware of that incident, she would have made Resident #76's husband leave. The Administrator reported that type of behavior would be inappropriate in front of anyone. The Administrator then stated what people do at home was their own business but in a living community it was inappropriate. The Administrator indicated she could not say if the resident would have been humiliated or upset by the incident. The Administrator was then asked, if her husband had done that to her in front of others, would it be humiliating and upsetting to her. The Administrator replied that it would be.<br><br>A review of the facility policy on Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property dated October 2022 revealed residents had the right to be free from abuse. It was the facility policy to investigate all alleged violations involving abuse. Facility staff should immediately report all such allegations to the Administrator and to the Ohio Department of Health (ODH) in accordance with the procedures in that policy. In cases where a crime was suspected, the Administrator would report the same to the local law enforcement in accordance with the facility's crime reporting policy. Under Protecting the Resident, staff should report all incidents/ allegations immediately to the Administrator or Designee. Under Initial Report, all incidents and allegations of abuse must be reported immediately to the Administrator/ designee. If abuse was alleged, the Administrator or his/ her designee would notify ODH immediately, but no later than two hours after the allegation was made.<br><br>This deficiency is cited as an incidental finding to Complaint Number OH00139646. |

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| F 0836<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923<br><br>Based on record review, staff interview, review of the facility's job description for Medical Assistants, employee file review, and information regarding professional standards, the facility failed to ensure medications were administered to residents by qualified employees who were licensed/ approved to pass medications in long term care settings by state/federal laws. This affected three residents (#27, #35, and #75) of three residents reviewed for medications but had the potential to affect all residents residing in the facility. The facility census was 103.<br><br>Findings include:<br><br>A review of Resident #27's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included adult onset diabetes mellitus, unspecified dementia. hypertension, and seizure disorder.<br><br>A review of Resident #27's medication administration record (MAR) for January 2023 revealed she received medications by four staff members who were medical assistants. Medical Assistant #95 administered medications to the resident that included insulin injections on 01/01/23, 01/02/23, 01/19/23- 01/21/23, and 01/23/23- 01/25/23. Medical Assistant #500 administered medications to the resident on 01/07/23. Medical Assistant #515 administered medications to the resident on 01/08/23 and 01/16/23. Medical Assistant #530 administered medications to the resident on 01/14/23 and 01/15/23.<br><br>A review of Resident #35's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease, adult onset diabetes mellitus, stage 3 chronic kidney disease, bipolar disorder, intellectual disability, seizure disorder, and hypertension.<br><br>A review of Resident #35's MAR's for January 2023 revealed the resident received medications from three staff members who were medical assistants. Medical Assistant #500 administered medications to the resident on 01/15/23. Medical Assistant #515 administered medications to the resident on 01/01/23, 01/21/23, and 01/22/23. Medical Assistant #530 administered medications to the resident on 01/02/23, 01/11/23, 01/20/23, and 01/25/23.<br><br>A review of Resident #75's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included adult onset diabetes mellitus, chronic obstructive pulmonary disease, history of a stroke, hypertension and chronic pain syndrome.<br><br>A review of Resident #75's MAR for January 2023 revealed she received medications from three staff members who were medical assistants. Medical Assistant #500 administered medications to the resident to include insulin injections on 01/15/23. Medical Assistant #515 administered medications to the resident on 01/01/23, 01/21/23, and 01/22/23. Medical Assistant #530 administered medications to the resident on 01/02/23, 01/11/23, 01/20/23 and 01/25/23.<br><br>(continued on next page) |

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| F 0836<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The facility identified they had four staff members who were medication techs/medical assistants that were being permitted to administer medications to the residents in the nursing facility. Medical Assistant #95, #500, #515 and #530 were the four medical assistants being used to administer medications to the facility's 103 residents.<br><br>A review of the undated job description for Medical Assistants revealed the medical assistants primary purpose was to assist the nurse in meeting clinical needs of the residents in accordance with federal and state guidelines, as well as in accordance with their established policies and procedures. Job functions included administering medications as ordered including intramuscular, intradermal, and subcutaneous injections. Job functions that could not be performed included not administering intravenous medications and performing any duties beyond their scope of practice.<br><br>A review of the employee file for Medical Assistant #95 revealed he had a hire date of 10/05/22. His position/ job title was a Med Tech. He was hired full time working between 36 and 40 hours per week. A review of his application for employment revealed his work experience indicated he was a certified clinical medical assistant (CCMA). His past work experience was in physician's offices and working for a school district. He performed injections in the physician's office and gave daily medication when working for a school district in another state. His employee file included a copy of his certification from National Healthcare Association (NHA) and was indicated to have completed the requirements set forth by the NHA as a certified clinical medical assistant. There was no evidence in his employee file of him being a State tested Nursing Assistant (STNA) with certification as a medication aide in the State of Ohio.<br><br>A review of the employee file for Medical Assistant #500 revealed she had a hire date of 11/22/22. Her position/ job title was a Med Tech. She reported to the Director of Nursing (DON) and was indicated to be a full time employee. Her application for employment revealed she had worked as a STNA and also had experience as a phlebotomist. She also completed the Certified Medical Assistant (CMA) course on 04/19/21 and worked in a physician's family practice office. A review of her certification from NHA revealed she had successfully completed the requirements set forth by the NHA as a CCMA on 04/19/21 and had an expiration date of 04/19/23. There was no evidence that she completed any training or was certified as a medication aide by the State of Ohio.<br><br>A review of Medical Assistant #515's employee file revealed she had a hire date of 11/19/22. Her position/ job title was a Med Tech. She reported to the DON and was a full time employee. A review of the employee's application for employment revealed she had experience as a medical assistant in physician's offices. Her work experience indicated that she filled injections and performed dressing changes. There was no evidence she had experience in administering medications as part of her work history. A review of her certification from NHA revealed she successfully completed the requirements set forth by NHA as a CCMA. The effective date of that certification was on 04/25/22 and did not expire until 04/25/24. There was no evidence in her employee file of her being a STNA or receiving any certification as a medication aide in the State of Ohio.<br><br>(continued on next page) |

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| | 365394 | A. Building<br>B. Wing | 02/01/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Continuing Healthcare at Adams Lane | 1856 Adams Lane<br>Zanesville, OH 43701 |

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| F 0836<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A review of Medical Assistant #530's employee file revealed she had a hire date of 10/05/22. Her position/ job title was Med Tech working full time hours and reporting to the DON. Her application for employment indicated she had work experience as a CMA in a physician's family practice and behavioral health services. She had experience with injections but none of work experiences listed indicated she had administered medications to clients. Her certification from American Association of Medical Assistants (AAMA) was a copy and was so small further information was unobtainable. Her employee file did not show evidence of her being a STNA or receiving any certification as a medication aide in the State of Ohio.<br><br>The facility denied having a medication administration policy that addressed the use of medical assistants to administer medications. The only information they provided was the job description that they recently developed for Medical Assistants and information they were able to obtain from Ohio State Society of Medical Assistants.<br><br>A review of the Ohio State Society of Medical Assistants Scope of Practice revealed in the specialized world of healthcare, one versatile professional stood out- the CMA (AAMA). That credential represented a medical assistant who had been certified by the Certifying Board of the American Association of Medical Assistants (AAMA). Medical assistants were multi-skilled who assumed a wide range of roles in physician's offices and other health care settings. Clinical duties they could perform included preparing and administering medications, including by intramuscular, intradermal, and subcutaneous injections as directed by a physician or other licensed provider. They could also perform phlebotomy and wound care/ dressing changes. It referenced seven different Ohio Administrative Codes to include OAC 4730.203 (Delegation of administration of drug), OAC 4723.489 (Delegated Authority to Administer Drugs), and OAC 4723.48 (Delegation of Authority to Administer Certain Drugs).<br><br>Additional information obtained from the Ohio State Society of Medical Assistants for Scope of Practice for Medical Assistants under Ohio Law revealed medical assisting scope of practice was determined primarily by state law. This paper would explain the scope of practice for medical assistants under Ohio Law. Ohio law classified medical assistants as unlicensed persons. The following was an excerpt from the Ohio Administrative Code (OAC) (State Medical Board of Ohio) addressing physician delegation to unlicensed persons such as medical assistants. Definitions under Rule 4731-23-01 revealed on-site supervision meant that the physical presence of the physician was required in the same location (e.g., the physician's office suite) as the unlicensed person to whom the medical task had been delegated while the medical task was being performed. On-site supervision did not require the physician's presence in the same room. Tasks included but was not limited to a routine medical service not requiring the special skills of a licensed provider. Unlicensed person was defined as an individual who was not authorized or otherwise specifically authorized by the Revised Code to perform the delegated medical task. When a physician delegated the administration of drugs, that physician should provide on-site supervision. Ohio law permitted Advanced Practice Nurses, including nurse practitioners to delegate to knowledgeable and competent unlicensed personnel such as medical assistants the administration of medications as long as certain conditions were met. A person not otherwise authorized to administer drugs may administer a drug to a specified patient if all of the following conditions were met: the advanced practice registered nurse was physically present at the location where the drug was administered.<br><br>(continued on next page) |

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| F 0836<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Other information provided by the facility were search results for Medical Assistant programs including information from local community colleges about the role of medical assistants in different setting. The information provided for review asked if Medical Assistants work in nursing homes. It indicated the typical nursing home did not hire for the position of medical assistant. The type of position they most often needed to fill was that of a CNA (Certified Nursing Assistant), Nurse Aide, PCW or a medication aide. That meant their job title would likely not be a medical assistant. If you completed a medical assistant program and wanted to work in a nursing home, then it may be required that they gain additional training such as with Alzheimer's/ Dementia. Some states, or with certain employers, they may be required to obtain your CNA license. In a nursing home, their responsibilities would likely revolve around feeding, bathing, changing, repositioning and giving medication. One thing to note, they may see a job listing for nursing homes hiring MA's but that was often times referring to a Medication Aide not a Medical Assistant.<br><br>Information on Job Placement for Different Types of Medical Assistants/ Medical Assistants Job Placement dated 05/13/20 revealed under Clinical Medical Assistant the clinical medical assistant worked directly alongside doctors, nurses and other healthcare professionals, providing patient care. The duties of a clinical medical assistant were regulated by state laws and could differ from state to state. Some typical duties may include performing basic tests and dressing wounds. Under Where I Can Work as a Medical Assistant included long term care facilities (nursing homes, assisted living facilities). They were identified as another popular choice for medical assistants looking for job placement.<br><br>Under a website for [NAME] University, Where Do Medical Assistants Work? 7 Settings Beyond the Clinic dated 04/06/17 revealed nursing care facilities were #7. It indicated if they had a passion for senior citizens, assisted living and nursing homes also offered opportunities for medical assistants. With the aging baby [NAME] generation, there was a growing demand for senior living services. Medical assistants in that environment typically helped residents with daily living tasks, take vital signs and maintain medical records.<br><br>On 01/25/23 at 12:27 P.M., an interview with a nurse that wanted to remain anonymous revealed she did have concerns with the facility utilizing aides to administer medications and perform treatments to residents that was outside their scope of practice. She stated medication aides were not allowed to give insulin, narcotics, cardiovascular medications and blood thinners. She reported she was told the facility had a new policy from the corporate office that allowed the medication aides to administer those things. She stated she searched their names in the nurse aide registry and on the Ohio Board of Nursing site and none of the four names she searched came back to show they were qualified to pass medications. She looked at the Ohio Administrative/ Revised Codes and they still were not permitted to administer those types of medications. She knew for a fact they were giving those medications. She identified the four employees by name and indicated they were Medical Assistant #95, #500, #515, and #530. She confirmed they had given medications to Resident #27, #35 and #75, along with other residents.<br><br>On 01/25/23 at 1:25 P.M., an interview with Licensed Practical Nurse (LPN) #55 confirmed the facility was using medication techs/ medical assistants to pass medications. She denied she was aware of them practicing outside their scope. She reported they could give injections, narcotics based on their job description. What they were qualified to do was very gray.<br><br>(continued on next page) |

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| F 0836<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 01/25/23 at 2:58 P.M., an interview with Medical Assistant #95 revealed he did work in the facility as a medication tech. He stated he was a CCMA. He did medication passes/administration to include insulin injections, blood sugar checks, collecting blood/ urine/ sputum specimens. He also signed receipt of medications from the pharmacy. There were no medications they were not allowed to administer. They could give narcotics, administer enteral feeding and medications via a gastrostomy tube, and perform trach care. He reported the certification he had allowed him to do more than the normal medication techs could.<br><br>On 01/30/23 at 2:20 P.M., an interview with Regional Nurse Consultant #700 revealed the facility just started using medical assistants to pass medications to the residents in the facility on 10/05/22. They were having staffing issues and had a medical assistant apply. With the review of his application and certification, it indicated they were permitted to administer medications. They reached out to the Ohio Board of Medicine and was informed that they do not oversee the practice of aides and referred them to the Ohio Department of Health. She reached out to the American Association of Medical Assistants by email and did not receive a response. She was having difficulty finding any guidance on what medical assistants could do in the long term care setting. She did read information under the Ohio State Society of Medical Assistants regarding the need for medical assistants to work directly under a physician or an advanced level provider. She reported that was a little gray to her on what they meant by working directly under a physician. She did not know if that meant they had to work in a physician's office with the physician or advanced level provider being on site or if it meant they could work in the long term care facility with the physician providing oversight. What they read from different sites they searched was that the medical assistants could find employment in nursing homes. They developed the Job Description for a Medical Assistant off the information they got from the Ohio State Society of Medical Assistants on what medical assistants can do. She could not find anything under the state and federal laws/ regulations providing guidance to the use of medical assistants in the long term care facility setting.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00139672. |