STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365794	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pataskala Oaks Care Center	144 East Broad Street Pataskala, OH 43062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of self reported incident, and facility policy review, the facility failed to ensure a complete and timely abuse investigation was conducted for one resident, Resident #4, of two residents reviewed for abuse. The facility census was 58.Findings include:Review of Self-Reported Incident (SRI) #272660, submitted on 03/29/26, revealed Resident #2 reported to a nurse that CNA #283 pinched Resident #2's right arm during a transfer from bed to wheelchair. The SRI documented Resident #2 also alleged CNA #283 slapped Resident #2 and called Resident #2 an inappropriate name. The SRI documented Resident #2 had a small faint bruise on the right outer forearm, complained of discomfort to the arm, and reported pain at a level two on a pain scale of zero to 10. The SRI documented Resident #2 stated she felt safe at the facility and appeared to be at baseline.Review of SRI #272660 revealed CNA #283 and CNA #486 were interviewed separately. CNA #283 and CNA #486 both stated Resident #2 slapped CNA #283 and called staff an inappropriate name during the transfer. The SRI documented that, upon notification of the allegation to the Administrator on 03/29/26, the Administrator obtained a statement from CNA #283 and suspended CNA #283 pending the investigation. The Administrator interviewed Resident #2, CNA #486, and two nurses. The Administrator notified the Medical Director, Director of Nursing, and Resident #2's responsible party.Review of the facility-provided assignment information revealed CNA #283 provided care to Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11. Of those 11 residents, Resident #2 and Resident #4 had BIMS scores below 8. The facility interviewed the other residents assigned to CNA #283; however, documentation provided did not show a skin assessment, injury assessment, or other assessment was completed for Resident #4 when the abuse allegation involving CNA #283 was brought to the facility's attention on 03/29/26.Review of Resident #2 medical record reveaeld the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, schizoaffective disorder, unspecified dementia, and major depressive disorder. Review of Resident #2's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) score of seven, indicating cognitive impairment. The resident had no hallucinations, delusions, or behaviors during the look back period. Resident #2 was coded to use antipsychotic, antianxiety and antidepressant meication in their care. The resident had limited mobility, required the use of a wheelchair, and was dependent on staff for toilet hygiene and showers. Review of Resident #4's Diagnosis Report, dated 05/13/26, revealed Resident #4 was admitted to the facility on [DATE], with a re-entry/admission date of 12/26/25. Diagnoses included Alzheimer's disease, post-traumatic stress disorder, unspecified dementia with behavioral disturbance, anxiety disorder, dysphagia, apraxia, peripheral vascular disease, severe protein-calorie malnutrition, and sleep apnea.Review of Resident #4's Minimum Data Set (MDS) 3.0 assessment, dated 04/14/26, revealed Resident #4 was rarely or never understood. The MDS documented the BIMS was not completed because Resident #4 was rarely or never understood. The MDS documented Resident #4's decision-making for daily tasks was severely impaired.Review of Resident #4's Brief Interview of Mental Status (BIMS) Evaluation, effective 04/13/26 at 10:46 A.M., revealed the BIMS should not be conducted because Resident #4 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	was rarely or never understood. The staff assessment documented Resident #4's decision-making regarding tasks of daily life was severely impaired.Review of Resident #4's care plan revealed the resident had focus areas related to cognitive impairment, communication, psychosocial/behavioral needs, activities of daily living, skin risk, and safety needs. The care plan included interventions for staff to anticipate and meet Resident #4's needs, assist with communication, use simple and direct communication approaches, monitor for changes in behavior or condition, monitor skin condition, and report abnormalities.Review of Resident #4's Skin Check, effective 03/24/26 at 5:06 A.M., revealed Resident #4's skin was warm and dry, skin color was within normal limits, and skin turgor was normal. The assessment documented no external device was present. The foot evaluation was completed, and no new skin issues were found.Review of Resident #4's skin check log revealed skin assessments were completed on 03/13/26, 03/24/26, 03/31/26, 04/17/26, 04/30/26, 05/14/26, 05/18/26, 05/20/26, and 05/27/26. The skin check log did not include a skin assessment dated [DATE], the date Resident #2 reported the abuse allegation involving CNA #283.Review of Resident #4's Skin Check, effective 03/31/26 at 2:49 A.M., revealed Resident #4's skin was warm and dry, skin color was within normal limits, and skin turgor was normal. The assessment documented no external device was present. The foot evaluation was completed, and no new skin issues were found. This was the next documented skin check for Resident #4 after the abuse allegation was reported on 03/29/26.Interview on 05/13/26 at 2:34 P.M. with the Administrator confirmed SRI #272660 was filed on 03/29/26 after Resident #2 reported an allegation of abuse involving CNA #283. The Administrator confirmed Resident #4 was unable to communicate. The Administrator stated the facility did not complete a skin assessment for Resident #4 when the allegation was brought to the facility's attention. The Administrator stated the facility did not complete the skin assessment sooner because staff felt there was nothing to the allegation due to Resident #2's history and statements toward others. The Administrator confirmed the facility did not complete a timely skin assessment for Resident #4 as part of the abuse investigation, despite Resident #4 being unable to communicate.Review of the facility policy titled Abuse, Neglect, Misappropriation, and Exploitation, effective 06/2016 and updated on 11/29/16 and 08/12/25, revealed the facility was required to protect residents from abuse, neglect, and mistreatment. The policy documented allegations of abuse were to be reported, investigated, and addressed to ensure resident safety. The policy documented the facility was responsible for completing a thorough investigation when an allegation of abuse was reported. The policy included investigation steps such as identifying involved residents and staff, assessing residents for injury or change in condition, obtaining statements/interviews as appropriate, reviewing relevant documentation, notifying appropriate parties, and taking action to protect residents from further potential abuse or harm.