

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365794	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER Pataskala Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure residents receiving psychotropic medications were educated on the risks/ benefits associated with the use of psychotropic medications, and informed consent was obtained from the resident and/ or their representative prior to use. This affected five (Resident #1, #5, #27, #30, and #35) of five residents reviewed for unnecessary medications. The facility census was 50. Findings include: 1. Review of Resident #35's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included schizo-affective disorder, bipolar disorder, and anxiety disorder. Review of Resident #35's physician's orders revealed she was receiving the following psychotropic medications: Aripiprazole (an antipsychotic medications) 10 milligrams (mg) by mouth (po) once a day for bipolar disorder, Ativan (an anti-anxiety medication) 0.5 mg po twice a day for anxiety disorder, Trazadone (an anti-depressant medication) 100 mg po once daily for anxiety disorder, and Desvenlafaxine ER (an anti-depressant medication) 100 mg po once daily for depression. Review of Resident #35's electronic medical record (EMR) revealed it was absent for any signed consents being obtained for the use of psychotropic medications. There was no evidence of the resident having been provided education on the risks/ benefits associated with the use of the four psychotropic medications she was receiving as required. On 08/20/25 at 12:41 P.M., an interview with the Director of Nursing (DON) confirmed there was no documented evidence of Resident #35 having been informed of the risks/ benefits associated with the psychotropic medications she was receiving. She further confirmed they did not have a signed consent for the use of those psychotropic medications. She reported the facility's social service designee should have been the one to obtain the consents for the use of those medications. On 08/20/25 at 2:14 P.M., an interview with Social Service Designee (SSD) #1 revealed she did not have any signed consents from Resident #35 or her representative showing evidence they were provided education on the risks and benefits associated with the use of the resident's multiple psychotropic medications. A signed consent was later provided by the facility that had not been obtained from the resident until 08/20/25, after the facility's DON was asked about it. The signed consent provided only included the resident's signature and date signed but did not list out the psychotropic medications used, what it was being used for, or the risks/ benefits associated with it's use. 2. Medical record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including nontraumatic chronic subdural hemorrhage, fracture of third lumbar vertebra, cerebral infarction, hypertension, diabetes mellitus, major depressive disorder, hemiplegia and hemiparesis, and congestive heart failure. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the annual Minimum Data Set (MDS) assessment, dated 08/06/25, revealed Resident #5's Brief Interview for Mental Status (BIMS) score was 9 out of 15, which indicated moderately impaired cognition. Review of a physician order, dated 08/13/25, revealed the order for Aripiprazole 5 milligrams (mg) one tablet by mouth daily for moderate dementia with behaviors and moderate major depressive disorder; review of a physician order, dated 06/23/25, revealed the order for Sertraline HCL 75 mg one tablet by mouth daily for depression; review of a physician order, dated 04/14/25, revealed the order for Trazadone HCL 50 mg one tablet by mouth daily for insomnia. Review of Resident #5's consent form titled, Informed Consent for Psychoactive Medication Use, dated 06/06/24, revealed the section of the form which would indicate the resident had been informed of and understood the reason for/risk of using a psychoactive medication was blank. The medication and diagnosis sections were blank. Interview on 08/21/25 at 11:57 P.M. with the Director of Nursing (DON) confirmed there was no documented evidence of Resident #5 having been informed of the risks/ benefits associated with the psychotropic medications he was receiving. She further confirmed that although the consent form for the use of those psychotropic medications was signed by the resident, the medication and diagnosis sections were blank and failed to indicate which psychotropic medications were used and for which diagnoses, and of the risks/ benefits associated with use. 3. Medical record review revealed Resident #30 was admitted to the facility on [DATE] with diagnoses including dementia, chronic kidney disease, diabetes mellitus, anxiety disorder, schizophrenia, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/21/25, revealed Resident #30's Brief Interview for Mental Status (BIMS) score was 05 out of 15, which indicated severely impaired cognition. Review of Resident #30's Medication Administration Record (MAR), dated August 2025, revealed the physician orders for the following psychoactive medications: Escitalopram Oxalate 10 mg one tablet by mouth daily for major depressive disorder; Mirtazapine 7.5 mg one tablet by mouth daily for mood/appetite; and Buspirone 7.5 mg one tablet by mouth three times per day for anxiety. Review of Resident #20's electronic medical record (EMR) revealed no evidence of the facility's consent form, Informed Consent for Psychoactive Medication Use. Interview on 08/21/25 at 3:25 P.M. with the Director of Nursing (DON) confirmed there was no documented evidence of Resident #30 having been informed of the risks/ benefits associated with the psychotropic medications she was receiving. She further confirmed there was not a signed consent for the use of those psychotropic medications. 4. Review of the medical record for Resident #1, revealed an admission date of 04/17/25. Diagnoses included but were not limited to dependence on respirator (ventilator) status, acute and chronic respiratory failure with hypoxia and anxiety disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15. The resident was assessed to require total (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependence on all aspects of assisted daily living activities. Review of the physician order dated 04/18/25 for Resident #1 revealed paroxetine HCL (Hydrochloric acid) 30 mg one tablet once a day. Review of the consent form titled Informed Consent for Psychoactive Medication Use, dated 04/17/25, for Resident #1 revealed the section of the form which indicated the resident had been informed of and understood the reason for/risk of using psychoactive medication and diagnosis were blank. Interview on 08/21/25 at 11:20 A.M. with the DON confirmed the informed Consent for Psychoactive Medication use form for Resident #1 did not indicate the resident had been informed of and understood the reason for/risk of using a psychoactive medication and the diagnosis for which it is being used for due to the areas being blank. 5. Review of the medical record for Resident #27 revealed an admission date of 01/08/24. Diagnoses included but were not limited to: Unspecified Atrial Flutter; Pain; Rhabdomyolysis, unspecified fall; Essential Hypertension; Unspecified Heart Failure, Chronic Obstructive Pulmonary Disease with Lower Respiratory Infection; Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms; Ventricular Flutter; Malignant Neoplasm of Bladder; Acute on Chronic Diastolic Congestive Heart Failure Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 13 out 15 indicating cognitive intactness. Review of Resident #27's medication orders revealed an order for Duloxetine 80 milligrams(mg), one tablet by mouth once daily for depression. The record also contained an order for Buspirone HCL 5 mg, one tablet by mouth two times daily for anxiety. Resident #27's record also revealed orders to monitor the effects of antidepressants. The orders were to observe closely for significant side effects of Anti-Anxiety medication including drowsiness, slurred speech, dizziness, nausea, aggressive or impulsive behavior every shift. Also, there was an order for Serotonin Syndrome Monitoring which included monitoring for increased agitation, restlessness, rapid HR, high BP, dilated pupils, loss of muscle coordination or twitching muscles, muscle rigidity, heavy sweating, diarrhea, headache. Notify medical provider if symptoms are noted. Review of Resident #27's medical record revealed a form titled Informed Consent for Psychoactive Medication Use. This consent form was signed by Resident #27 and dated 11/07/23. The remaining form, including the name of the medication, a supporting diagnosis, and witness to the form, was left incomplete. Interview on 08/21/25 at 11:57 A.M. with the Director of Nursing (DON) #40 confirmed there was no documented evidence of Resident #27 having been informed of the risks/ benefits associated with the psychotropic medications he was receiving. She further confirmed that although the consent form for the use of those psychotropic medications was signed by the resident, the medication and diagnosis sections were blank and failed to indicate which psychotropic medications were used and for which diagnoses, and of the risks/ benefits associated with use. Review of the facility's policy on Use of Psychotropic Medications dated 03/31/25 revealed it was (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the intent of the policy to ensure residents only received psychotropic medications when other non-pharmacological interventions were clinically contraindicated. Those medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience. Prior to initiating or increasing a psychotropic medication, the resident, family, and/ or resident representative must be informed of the benefits, risks, and alternatives for medications, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to obtain an assessment and physician order for a wander guard for one resident (#5) out of one resident reviewed for restraints. In addition, based on observation, interview, record review and policy review, the facility failed to timely change PICC (peripherally inserted central catheter) line access dressings as ordered for three residents (#2, #21 and #33) of three residents reviewed. The facility census was 50. Findings include: 1. Medical record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including nontraumatic chronic subdural hemorrhage, cerebral infarction, hypertension, diabetes mellitus, major depressive disorder (MDD), anxiety disorder, post-traumatic stress disorder (PTSD), hemiplegia and hemiparesis, and congestive heart failure. Review of the annual Minimum Data Set (MDS) assessment, dated 08/06/25, revealed Resident #5's Brief Interview for Mental Status (BIMS) score was 09 out of 15, which indicated moderately impaired cognition. Review of a nursing progress note, dated 08/12/25 at 3:49 P.M., revealed Resident #5 was outside this afternoon per his usual routine sitting on the patio and chose to go off of the patio and wheeled down the sidewalk. His wheelchair went off the path causing him to slide out of his wheelchair. The unit manager was first outside and contacted emergency medical services (EMS) after the fall. Emergency medical technicians assessed the resident, took vital signs, and transferred him to the stretcher. Resident was alert and oriented and able to answer questions with noted abrasions to left arm and head. Resident transported to emergency room (ER). Nurse practitioner (NP) and family notified. Review of the Care Plan, dated 08/13/25, revealed Resident #5 was an elopement risk due to personal choice and cognitive deficits with interventions including to apply a wander guard (security device that alerts staff when a resident has wandered from a protected zone) to wheelchair, to check wander guard bracelet at bedtime for proper function and placement, and to observe for and document any exit seeking behaviors. Interview with Resident #5 on 08/19/25 at 8:38 A.M. revealed he wants to be able to go outside whenever he chooses to do so. The resident stated that he had fallen out of his wheelchair last week and is no longer allowed to go outside unaccompanied. Review of nursing progress note, dated 08/19/25 at 5:43 P.M., revealed the interdepartmental team (IDT) met to discuss the placement of wander guard to wheelchair. The resident's behavior has improved with no delusions or hallucinations since his visit with the psychiatric certified nurse practitioner (CNP) with medication changes. IDT removed wander guard from wheelchair. Interview 08/21/2025 at 10:18 A.M. with Licensed Practical Nurse (LPN)/MDS #62 confirmed there was not a physician order for Resident #5's wander guard. LPN #62 stated nursing put the wander guard on the resident to keep an eye on him after his fall, but removed it from his wheelchair earlier this morning. Interview on 08/21/25 at 12:11 P.M. with Unit Manager/Registered Nurse (RN) #38 confirmed there was not a physician order for Resident #5's wander guard which was applied to his wheelchair. 2. Review of the medical record for Resident #2, revealed an admission date of 12/30/24. Diagnoses included but were not limited to dependence on respirator, pressure ulcer of the sacral region, methicillin resistant staphylococcus aureus infection and type 2 diabetes mellitus. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12 out of 15 suggested moderate cognitive impairment. Review of the physician order dated 06/15/25 for Resident #2 revealed to change PICC line dressing every week on Sunday nights. Observation on 08/21/25 at 8:58 A.M. of Resident #2 revealed a PICC line to the upper left arm with a dressing dated 08/10/25. Observation on 08/21/25 at 9:00 A.M. of Resident #2's PICC dressing to the left upper arm with the Director of Nursing (DON) confirmed the dressing was dated for 08/10/25 indicating it was changed that day and not weekly on 08/17/25 (Sunday) per the order. 3. Review of the medical record for Resident #21, revealed an admission date of 07/13/23. Diagnoses included but were not limited to multiple sclerosis, muscle weakness and peripheral vascular disease. Review of the most recent (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicating intact cognition. Review of the physician order dated 08/10/25 for Resident #21 revealed to change PICC line dressing every week on Sunday nights. Observation on 08/20/25 at 8:22 A.M. of Resident #21 revealed a PICC line to the upper right arm with a dressing dated 08/09/25. Observation on 08/01/25 at 9:04 A.M. of Resident #21's PICC dressing to right upper arm with the DON confirmed the dressing was dated 08/09/25 indicating it was changed that day and not weekly on 08/17/25 (Sunday) per order. 4. Review of the medical record for Resident #33, revealed an admission date of 02/22/25. Diagnoses included but were not limited to chronic kidney disease, pressure ulcer of sacral region, type 2 diabetes mellitus without complications and sepsis. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicating intact cognition. Review of the physician order dated 08/03/25 for Resident #33 revealed change PICC line dressing every week on Sunday nights. Observation on 08/18/25 at 9:41 A.M. of Resident #33 revealed a PICC line to the upper left arm with a dressing not dated. Observation on 08/01/25 at 9:04 A.M. of Resident #33's PICC dressing to right upper arm with the DON confirmed the dressing was not dated indicating it is unknown as to when the dressing was changed and it is their practice to date dressings when changed. Review of the facility policy titled PICC/Midline/CVAD Dressing Change implemented on 03/31/25, revealed it is the policy of the facility to change PICC, midline or CVAD dressings weekly or if soiled.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, observation and facility policy review, the facility failed to implement preventive pressure ulcer skin interventions for 5 residents (#33, #2, #18, #4, and #63.) of 5 reviewed. The facility census was 50. Findings include:1. Review of the medical record for Resident #33, revealed an admission date of 02/22/25. Diagnoses included but were not limited to chronic kidney disease, pressure ulcer of sacral region, type 2 diabetes mellitus without complications and sepsis. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15. The resident was assessed to require total dependence on toilet hygiene, shower/bathe self, bed mobility and transfers. This resident was also at risk for pressure ulcers and to have a stage 3 and stage 4 pressure ulcer. Review of the physician order dated 02/24/25 for Resident #33 revealed an air mattress to bed. Review of the plan of care revised on 04/25/25 for Resident #33 revealed at risk for pressure ulcer development with an intervention including but not limited to an air mattress to bed. Review of the most recent Braden Scale for Predicting Pressure Sore Risk dated 05/21/25 for Resident #33 revealed a score of 12 on a scale of 6 (high risk) to 23 (no risk) which indicated the resident was at high risk for skin breakdown. Review of the most recent weight obtained on 08/20/25 for Resident #33 revealed him to be 151.2 pounds. Observation on 08/18/25 at 9:14 A.M. of Resident #33 revealed him to be in bed on an air mattress set to firm (highest setting for the air mattress). Per the Patient weight guide the bed was set to 400 pounds. Observation on 08/19/25 at 2:00 P.M. of Resident #33 revealed him to be in bed on an air mattress set to firm indicating the bed to be set for 400 pounds. Observation and Interview on 08/20/25 at 2:28 P.M. with Licensed Practical Nurse (LPN) # 39 verified Resident #33's air mattress was set to firm indicating 400 pounds instead of his current weight of 151.2 pounds. 2. Review of the medical record for Resident #2, revealed an admission date of 12/30/24. Diagnoses included but were not limited to dependence on respirator, pressure ulcer of the sacral region, methicillin resistant staphylococcus aureus infection and type 2 diabetes mellitus. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12 out of 15 suggested moderate cognitive impairment . The resident was assessed to require total dependence on bed mobility, toilet hygiene, shower/bathe self and transfers. This resident was also assessed to have a two pressure ulcer injuries present upon admission/reentry of a stage 3 and a stage 4. Review of the most recent Braden Scale for Predicting Pressure Sore Risk dated 06/23/25 for Resident #2 revealed a score of 13 on a scale of 6 (high risk) to 23 (no risk) which indicated the (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident was at moderate risk for skin breakdown. Review of the physician order dated 12/30/24 for Resident #2 revealed a pressure reducing mattress to bed. Review of the most recent weight obtained on 08/20/25 for Resident #2 revealed her to be 120.8 pounds. Observation on 08/18/25 at 9:47 A.M. of Resident #2 revealed her to be in bed on an air mattress set to firm indicating the bed to be set for 400 pounds. Observation on 08/19/25 at 8:12 A.M. of Resident #2 revealed her to be in bed on an air mattress set to firm, indicating the bed to be set for 400 pounds. Observation an interview on 08/20/25 at 2:30 P.M. with LPN #39 verified Resident #2's air mattress was set to firm indicating 400 pounds instead of his current weight of 120.8 pounds. 3. Review of the medical record for Resident #18, revealed an admission date of 08/12/25. Diagnoses included but were not limited to anoxic brain damage, not elsewhere classified, acute respiratory failure, encephalopathy, type 2 diabetes mellitus without complications, and personal history of sudden cardiac arrest. Review of the physician order dated 08/11/25 for Resident #18 revealed a pressure reducing air mattress to bed. Review of the clinical admission data dated 08/12/25 revealed Resident #18 to have a Brief Interview for Mental Status (BIMS) score of 0 out of 15 indicated severe cognitive intactness, to have a pressure ulcer to the right gluteus and to be totally dependent on all aspects of daily living. Review of the plan of care dated 08/12/25 for Resident #18 revealed to be at risk for pressure ulcer development with an intervention including but not limited to an air mattress bed. Review of the most recent weight obtained on 08/13/25 for Resident #18 revealed him to be 238.6 pounds. Review of the most recent Braden Scale for Predicting Pressure Sore Risk dated 08/19/25 for Resident #18 revealed a score of 9 on a scale of 6 (high risk) to 23 (no risk) which indicated the resident was at very high risk for skin breakdown. Observation on 08/18/25 at 10:01 A.M. of Resident # 18 revealed him to be in bed on an air mattress set to medium indicating the bed to be set at 170 pounds. Observation on 08/19/25 at 8:15 A.M. of Resident #18 revealed him to be in bed on an air mattress set to firm indicating the bed to be set at 400 pounds. Observation and Interview on 08/20/25 at 2:36 P.M. with LPN #39 verified Resident #18's air mattress was set to firm indicating 400 pounds instead of his current weight of 238.6 pounds. 4. Review of the medical record for Resident # 4, revealed an admission date of 07/28/25 . Diagnoses (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included but were not limited to non pressure chronic ulcer of left heel and midfoot with unspecified severity, type 2 diabetes mellitus with foot ulcer, venous insufficiency, and osteomyelitis. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating intact cognition. The resident was assessed to require partial/moderate assistance with bed mobility, substantial/maximal assistance with transfers and total dependence on toilet hygiene, shower/bathe self. This resident was also assessed to be at risk for pressure ulcer injuries. Review of the plan of care dated 07/29/25 for Resident #4 revealed at risk for pressure ulcer development with an intervention including but not limited to an air mattress to bed. Review of the physician order dated 07/29/25 for Resident #4 revealed an order for an air mattress to bed. Review of the most recent weight obtained on 08/13/25 for Resident #4 revealed him to be 322.2 pounds. Review of the most recent Braden Scale for Predicting Pressure Sore Risk dated 08/18/25 for Resident #4 revealed a score of 17 on a scale of 6 (high risk) to 23 (no risk) which indicated the resident was at risk for skin breakdown. Observation on 08/18/25 at 9:56 A.M. of Resident #4 revealed him to be in bed on an air mattress set to medium indicating the bed to be set at 170 pounds. Observation on 08/19/25 8:14 A.M. of Resident #4 revealed him to be in bed on an air mattress set to medium indicating the bed to be set at 170 pounds. Observation and interview on 08/20/25 at 2:38 P.M. with LPN #39 verified Resident #4's air mattress was set to medium, indicating being set at 170 pounds and the resident's current weight to be 322.2 pounds. 5. Review of Resident #63's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included unspecified dementia without behavioral disturbances, muscle weakness, need for assistance with personal care, and palliative care. Review of Resident #63's clinical admission assessment dated [DATE] revealed the resident was admitted to the facility with an unstageable pressure ulcer to his left heel. It was classified as an unstageable pressure ulcer, due to the wound having slough and/ or eschar present, limiting the wound bed to be fully visualized to determine the extent of the wounds depth. It measured 0.5 centimeters (cm) by 2 cm and had a small amount of light green drainage present on the old dressing. His admission weight was 148.2 pounds. Review of Resident #63's physician's orders revealed he had an order in place for the use of an air mattress to his bed. He was also to have his heels elevated as tolerated to promote skin integrity. The elevation of his heels had been in place since his admission and the use of the air mattress was implemented on 08/15/25. Review of Resident #63's care plans revealed he had a care plan in place for being at risk for pressure (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ulcer development related to weakness, limited mobility, and dementia with cognitive deficits. His care plan reflected he was admitted to the facility with a pressure ulcer to his left heel. The care plan originated on 08/14/25 and included the goal for his pressure ulcer to show signs of healing by/through the review date. The interventions included the use of an air pressure mattress to his bed for comfort. The setting for the air mattress was left blank on the care plan. They were also to follow the facility policies/protocols for the prevention/treatment of skin breakdown. On 08/18/2025 2:30 P.M., an observation of Resident #63 noted him to be lying in bed. He had an air mattress to his bed, but his heels were not elevated and were in direct contact with the air mattress. There were a pair of heel boots on the nightstand next to his bed that were not being used to off-load his heels. On 08/20/25 at 12:53 P.M., an ongoing observation of Resident #63 noted him to be lying in bed on his right side. He had his knees bent and his legs were drawn up putting him in a fetal position. His air mattress remained on his bed and set on static, normal pressure. There was a dial that was to be used to adjust the firmness of the mattress based on the resident's weight. The current setting was at 350 pounds, which was the firmest setting (too firm for the resident with his weight of 148.2 pounds). Again, the resident did not have his heels elevated off the bed and they were in direct contact with the mattress. Approximately six minutes later, Certified Nursing Assistant #10 was observed to enter the resident's room with two new pillows that were in plastic wraps. She was stopped for an interview as she entered the room. On 08/20/25 at 12:59 P.M., an interview with CNA #10 confirmed Resident #63 did not have his heels elevated off the mattress to off-load pressure, which was why she was bringing the pillows into his room. She was questioned about the settings on the resident's air mattress and confirmed based on the resident's weight, it was not set properly. She confirmed the resident was nowhere near 350 pounds, which was what the air mattress was set on. At that time, RN #23 entered the room. She had previously been asked by the surveyor to come to the resident's room to verify his heels were not elevated and his air mattress was not set properly resulting in the mattress being too firm for the resident based on his stated weight. She confirmed Resident #63 was known to have a pressure ulcer to his left heel. She acknowledged the resident's heels were not off-loaded and his air mattress was not properly set according to his weight, which could delay his wound healing or make his pressure ulcers worse. She stated they would check to see how much the resident weighed and set his air mattress to the proper firmness accordingly. Review of the Med-Aire 8 alternating pressure mattress replacement system with low air loss user instructions provided by the facility revealed the medical device must be installed and operated in the manner for which it was intended. The user was responsible for reading and understanding the product user manual. Under indications for use, it was described as an effective pressure redistribution therapy, but was only a component of a comprehensive pressure injury management program. Support surfaces were not substitutes for turning, repositioning, or functional weight shifts. The product features indicated it had an analog control unit that included an easy to use pressure dial that was adjustable to the resident's weight and comfort. Under operation, pressure range selection was achieved by the user adjusting the pressure level of the air mattress, using the analog pressure dial, to a desired firmness based on personal comfort or weight setting. Review of the facility policy titled Bed Maintenance and Inspections revealed evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present that included but was not limited to provide appropriate, pressure-redistributing, support surfaces.		

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NAME OF PROVIDER OR SUPPLIER Pataskala Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, and staff interview the facility failed to accurately reflect the Resident code status in the electronic medical record and the paper copies in the facility binder used for emergencies. This affected two Residents (Resident #3 and #5) of the 22 residents reviewed for code status. The facility census was 50. Findings Include: 1. Review of Resident #3 medial record revealed admission to facility 04/22/24 for diagnoses including chronic obstructive pulmonary disease, diabetes mellitus type 1 with neuropathy (decreased sensation in nerve endings), high blood pressure, major depressive disorder, unspecified mood disorder, generalized anxiety disorder, unspecified disorders of adult personality and behavior, insomnia (inability to sleep), heart disease, chronic kidney disease. Review on 08/18/2025 at 11:53 A.M. of the code status binder at the nurse's station revealed an orange paper noting Resident #3 was a Full Code. Further review of the electronic medical record Point Click Care revealed Resident #3 was a Do Not Resuscitate-Comfort Care (DNR-CC) (do not provide heroic measures during end of life), order scanned in and signed by the medical provider on 08/14/24 and updated again on 05/03/25. Review of Resident #3 care plan revised on 02/13/25 revealed Resident #10 as a Do Not Resuscitate-Comfort Care Arrest (DNR-CCA) (provide heroic measures during end of life until the heart stops beating). Review of Resident #3's most recent Order Summary active as of 08/19/25 revealed Resident #3 was ordered a DNR-CC code status. Interview on 08/19/2025 3:42 P.M with the Charge Nurse, Register Nurse (RN) #30 revealed code status binder at nurse's station listed Resident #3 as a DNR-CC with the current signed order dated 05/03/25. RN #30 reported that the unit manager is responsible for updating the code status binder. Interview on 08/19/2025 at 3:50 P.M. with Unit Manger and Licensed Practical Nurse (LPN) #39 revealed she had updated the code status binder at the nurse's station that morning for Resident #3 and one other resident. LPN #39 admitted that the book was not updated as frequently as it should be. 2. Review of Resident #35's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), obstructive sleep apnea (OSA), adult-onset diabetes mellitus, and chronic kidney disease. Review of Resident #35's active physician's orders revealed she had an order in place to be a Do Not Resuscitate Comfort Care (DNR-CC). The order was initiated on 07/14/25. Review of a code status binder the facility had at the nurse's station to be used in the event revealed Resident #35 was a DNRCC. Review of the electronic medical record (EMR) revealed the resident was a DNRCC- Arrest. The DNR order form was signed by the advanced level provider on 05/28/25. The form indicated for a DNRCC- Arrest the provider would treat the resident as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions would cease and the DNR Comfort Care protocol would be implemented. For a DNR-CC, the DNR protocol would be effective immediately. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/19/25 at 3:42 P.M., an interview with RN #30 revealed she determined what a resident's code status was by checking the physician's orders in the EMR. If the computer was down, they had a code status book at the nurses station that informed them what the resident's code status was. She verified Resident #35's code status in the code status book identified the resident as DNRCC-A. She then verified the resident's code status was identified as being a DNR-CC when she checked the physician's orders in the EMR. She reported the managers were responsible for updating the code status book. On 08/19/25 at 3:50 P.M., an interview with LPN #39 confirmed she was the one who updated the residents' code status in the code status book. They liked to update the code status book at the time the code status was added or changed, but it did not always get done as timely as they liked. She acknowledged Resident #35's code status as indicated in her physician's orders identified her as a DNRCC and the code status book had her as a DNRCC-A. She further acknowledged the physician's orders showed the code status changed to a DNRCC on 07/14/25 and had not been updated in their code status book. Review of the facility's policy on Residents' Rights Regarding Treatment and Advanced Directives (undated) revealed it was the policy of the facility to support and facilitate a resident's right to request, refuse, and/ or discontinue medical or surgical treatment and to formulate advance directives. Upon admission, the facility would determine if the resident had executed an advanced directive, and if not, determine whether the resident would like to formulate an advanced directive. During the care planning process, the facility would identify, clarify, and review with the resident whether they desired to make any changes related to any advanced directives. Any decision making regarding the resident's choices would be documented in the medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR) documents accurately reflected diagnoses. This affected three (Resident #5, #3 and #8) of three residents reviewed for PASRR documents. The census was 50. Findings Include: 1. Medical record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including nontraumatic chronic subdural hemorrhage, cerebral infarction, hypertension, diabetes mellitus, major depressive disorder (MDD), anxiety disorder, post-traumatic stress disorder (PTSD), hemiplegia and hemiparesis, and congestive heart failure. Review of the annual Minimum Data Set (MDS) assessment, dated 08/06/25, revealed Resident #5's Brief Interview for Mental Status (BIMS) score was 09 out 15, which indicated moderately impaired cognition. Review of Resident #5's PASRR document, dated 06/06/24, under Section E: Indications of Serious Mental Illness, revealed the answer No was selected for the question: Does the individual have a diagnosis of any of the mental disorders listed below, check all that apply. There were no diagnoses selected. The PASRR document did not accurately reflect the diagnoses of anxiety, PTSD, or MDD. Interview on 08/21/25 at 1:40 P.M. with Social Services Designee (SSD) #1 confirmed Resident #5's PASRR document was not accurate and did not indicate the diagnoses of anxiety, PTSD, or MDD. SSD #1 stated that she would make this correction now and submit a new PASRR for the resident. 2. Record review on Resident #3 revealed admission to facility 04/22/24 for diagnoses including chronic obstructive pulmonary disease, diabetes mellitus type 1 with neuropathy, high blood pressure, major depressive disorder, unspecified mood disorder, generalized anxiety disorder, unspecified disorders of adult personality and behavior, insomnia, heart disease, chronic kidney disease. Record review of Resident #3 most recent Pre-admission Screening and Resident Review (PASARR) completed on 03/20/24 revealed mental health diagnoses of mood disorders, panic disorder other severe anxiety disorders, and insomnia. Record review of Resident #3 diagnosis list revealed new diagnoses of Schizo- affective disorder, unspecified type on 08/14/24, delirium due to known physiological condition on 01/17/25, and unspecified dementia without behavioral disturbances on 02/05/25. Record review of Resident # 3 most recent quarterly Minimum Data Set (MDS 3.0) dated 07/24/25 revealed Section I with diagnosis Schizophrenia and Non-Alzheimer's Dementia selected. Interview 08/19/2025 2:47 P.M. with Social Worker Designee (SWD) #1 revealed process for facility reviewing and completing the PASRR of newly admitted Residents as follows: SWD reviewed all PASRRs completed prior to admission to facility for accuracy and updates accordingly if needed with in 30 days. If Residents have not had a PASRR completed, then the SWD would complete a new one within 30 days of admission. SWD #1 further explained if a Resident has a change in condition or new diagnosis related to mental health, she would update the PASRR. SWD #1 reported she was notified (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by nursing staff during daily huddle meetings and during inter-disciplinary meetings of change in condition or new and updated diagnosis. SWD #1 verified that there has not been and updated PASRR completed for Residents #3 related to diagnosis of Schizo-affective disorder and dementia. 3. Review of Resident #8's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her diagnoses included major depressive disorder, anxiety disorder, psychotic disorder with delusions, and schizophrenia. Those diagnoses were in place on or before 05/25/22. Her diagnoses list was updated to reflect she had a new diagnosis of dementia of an unspecified severity with mood disturbance on 01/11/23. Review of Resident #8's Pre-admission Screening and Resident Review (PASRR) Identification Screens revealed the last PASRR completed for the resident was completed on 08/18/22. Her mental illness diagnoses were properly identified under section (E.) and included schizophrenia and a mood disorder. At the time of the PASRR's completion, section (D.): Medical Diagnosis was properly marked to reflect the resident did not have a diagnosis of dementia at the time the PASRR was completed. Resident #8's EMR was absent of any evidence of a new PASRR being completed, after the resident was diagnosed with dementia on 01/11/23. The last PASRR on file remained the PASRR that was completed on 08/18/22. Review of Resident #8's prior Minimum Data Set (MDS) assessments reflected the resident did have a decline in her mental and physical condition around the time she was newly diagnosed with dementia. A quarterly MDS assessment completed on 10/19/22 revealed the resident's cognition was only moderately impaired and she was independent to needing only a limited assistance for all of her activities of daily living (ADL) assistance. Her quarterly MDS assessment completed on 01/10/23 revealed Resident #8 now had severely impaired cognition and required supervision to an extensive assist with all her ADL's reflecting a decline in both her mental and physical status. On 08/19/25 at 2:45 P.M., an interview with Social Service Designee (SSD) #1 revealed she had worked at the facility for about three years now. It was her responsibility to review PASRR's upon a resident's admission to ensure they had been completed and were accurate. She reported for the residents that already resided in the facility, she would complete a new PASRR for a change in condition. She was asked what would be considered a change in condition and replied a decline, or if the resident went hospice. She was then asked about residents that received a new diagnoses of a mental illness and indicated she would do a new PASRR only if she was told that it was needed. When asked to clarify who would be the one to tell her when a new PASRR was needed to be completed, she stated nursing. She would be told in morning meeting. She stated, according to the county's Area Agency on Aging, she was not required to do a new PASRR when a new diagnoses of dementia was added. She acknowledged a new diagnosis of dementia with a decline in the resident's physical and/or mental status condition did require a new PASRR to be completed. She acknowledged the resident was given a new diagnosis of dementia on 01/11/23 and her quarterly MDS assessments completed on 10/19/22 and 01/10/23 did show she had a decline in both her mental and physical status. She reported she would go ahead and complete an updated PASRR Identification Screen due to the added diagnosis of dementia and a decline in her mental and physical status as a result. Review of the facility's policy titled, Resident Assessment-Coordination with PASARR Program, undated revealed this facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in them most integrated (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	setting appropriate to their needs. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the States' Medicaid rules for screening.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident's comprehensive care plans included care plans to address all the resident's diagnoses that they received medications for. This affected one (Resident #35) of 22 residents reviewed for care plans. The facility census was 50. Findings include: Review of Resident #35's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included schizo-affective disorder, bipolar disorder, anxiety disorder, and chronic pain syndrome. Review of Resident #35's physician's orders revealed she had orders in place to receive Melatonin (a supplement used in the treatment of insomnia) 10 milligrams (mg) by mouth (po) every night at bedtime for insomnia. The resident also had orders in place for the use of Senna Plus (stool softener) 8.6 mg- 50 mg po every day and FiberCon (bulk forming laxative) 625 mg with the directions to take two tablets one time a day for constipation. Review of Resident #35's active care plans revealed she did not have a care plan in place to address insomnia or constipation, despite receiving medications on a scheduled basis to manage both. Findings were verified by the Director of Nursing (DON). On 08/20/25 at 12:41 P.M., an interview with the DON verified Resident #35 was receiving Melatonin every night at bedtime for the treatment of insomnia and was also receiving Senna Plus and FiberCon daily for management of constipation. She was not able to see where either diagnoses of insomnia or constipation had been addressed in the resident's comprehensive care plans. On 08/20/25 at 12:55 P.M., an interview with Licensed Practical Nurse (LPN) #62 revealed she was the one who developed the residents' care plans. She asked if there were any questions pertaining to Resident #35's care plans. She was informed the resident was receiving two different medications for constipation and Melatonin for the treatment of insomnia with no care plans in place for either. She indicated the resident was having regular bowel movements and did not have an official diagnosis of constipation, so she did not feel she needed one. She was further informed the resident was receiving medical intervention for constipation (two different medications on a scheduled basis for constipation), and with medical interventions in place to address the problem, she should have a care plan in place to reflect such. She was also informed the resident was being treated for insomnia (by being given the supplement Melatonin), so she should have a care plan for that as well.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to maintain safe equipment for residents, which affected Resident #27. The facility also failed to maintain safety for Resident #10 identified as being a high fall risk. This affected two residents (#10 and #27) out of 3 residents reviewed for accidents. The facility census was 50.1. Review of the medical record for Resident #27 revealed an admission date of 01/08/24. Diagnoses included but were not limited to: Unspecified Atrial Flutter; Pain; Rhabdomyolysis, unspecified fall; Essential Hypertension; Unspecified Heart Failure, Chronic Obstructive Pulmonary Disease with Lower Respiratory Infection; Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms; Ventricular Flutter; Malignant Neoplasm of Bladder; Acute on Chronic Diastolic Congestive Heart Failure Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 13 of 15 which indicated cognitive intactness. The MDS also revealed the resident required assistance of one person for bed mobility, transfers and toileting. He required setup help only for meals. Review of a care plan dated 08/06/25, revealed Resident #27 was a fall risk due to a history of falls, weakness, impaired mobility, pain and difficulty ambulating. Interventions for wheelchair, footwear, and safety were implemented. For ADL interventions, bed mobility requires staff assistance of one with minimal to moderate assistance. Review of a care plan dated 08/06/25, revealed Resident #27 had altered respiratory status related to Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure with hypoxia. Interventions were put in place for oxygen via nasal cannula as ordered. The care plan failed to reveal an intervention for mobility bars. Review of Resident #27's progress note, dated 07/25/25 revealed Licensed Practical Nurse #400 was called into Resident #27's room by a (unknown) therapists who reported the resident had obtained a skin tear from a sharp area of his bedrail. A Band-Aid was placed over the sharp area and maintenance was notified. Review of incident report, dated 07/25/25 at 8:18 A.M., the resident obtained a skin tear on his left arm. The incident was unwitnessed. Resident #27 indicated there was a sharp place on his bed and a maintenance report was filed. On 08/20/25 at 2:23 P.M., an interview with Resident #27 revealed he had obtained a skin tear somewhere on my left arm there. He could not indicate which arm. He reported the hand rail on the left side of his bed had a sharp area on it which had torn his skin. Review of form titled Pataskala Oaks Care Center-Maintenance Log revealed a report on 07/25/25 which indicated a bed rail in Resident #27's room has a sharp piece sticking [arrow pointing upward] Band-aid covering it. The priority level on this was reported a High. This was confirmed by Maintenance Director #48 on 08/21/25. On 08/21/2025 at 3:08 P.M., an interview with Maintenance Director #48 revealed he was responsible for maintenance of the hand rails at the facility. These were checked on a monthly basis. When (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	someone would notify him of an issue he would fix it as soon as he could. He confirmed on 07/25/25, he received a maintenance request to repair the hand rail of Resident #27's bed, which had a sharp edge on it. 2. Record review of Resident #10 revealed admission to facility on 04/06/25 with diagnosis including cerebral palsy, quadriplegia (unable to use all four limbs), tracheostomy (whole in wind pipe to breath), suprapubic catheter (tube in bladder to urinate), neurogenic bladder (bladder that does not respond to being full), lung disease, congestive heart failure, two non-pressure ulcers of left thigh (chronic) and right thigh (chronic), cognitive communication deficit, low blood pressure, depression, anxiety, acid reflux, feeding tube, and non-insulin dependent diabetes mellitus. Record review of Resident #10 most recent quarterly Minimum Data Set (MDS 3.0) assessment dated [DATE] revealed resident was completely dependent on staff for all care areas. Record review of Resident #10 Order Summary dated 08/19/25 revealed Keep bed in low position when not providing care. Observation on 08/20/2025 at 12:13 P.M. revealed Resident #10 door was open with the privacy curtain pulled. Resident #10 was laying on his back with bed in high position. No staff were present in room. The Breath Call (a call light used for individuals who cannot use hands to push a button for a traditional call light system and requires the individual to blow into the apparatus to activate it) call light was out of reach of resident, pushed to right side of bed approximately 3 feet from bed. Interview on 08/20/2025 12:14 P.M. with Registered Nurse (RN) #23 verified Resident #10 Breath Call device not within reach of Resident and bed in high position. RN #23 reported the nursing aides were probably getting ready to get Resident #10 up and needed to go get something. RN #23 proceeded to lower bed and place the Breath Call device within reach of Resident #10.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, observation and interview, the facility failed to properly administer oxygen per nasal cannula as ordered by a physician. This affected three (Resident #12, Resident #27, and Resident #61) of three residents reviewed for oxygen use. The facility census was 50. Findings include: 1. Review of the medical record for Resident #12, revealed an admission date of 08/07/25. Diagnoses included but were not limited to: Acute Respiratory Failure with Hypercapnia; Dyspnea; Diarrhea; Gastroesophageal Reflux Disease without Esophagitis; Anemia in Chronic Kidney Disease; Long term use of Anticoagulants; Essential Hypertension; Chronic Diastolic Heart Failure; Unspecified Atrial Fibrillation; Chronic Kidney Disease Stage 3; and Pneumonia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 10 out of 15 indicating moderate cognitive deficit. Review of Resident #12's orders indicated he was ordered oxygen at 2 Liters (L) via nasal cannula continuous. On 08/18/2025 at 10:31 A.M., and observation of Resident #12 revealed he was on Oxygen via nasal cannula. His Oxygen concentrator was set at 4 L. On 08/19/2025 at 11:48 A.M., Observation of Resident #12 revealed oxygen on via nasal cannula. His concentrator flow rate was set to 4L. Tubing was not dated. This was confirmed by Registered Nurse (RN) #30. On 08/19/2025 at 12:05 P.M., RN #30 confirmed the oxygen flow rate for Resident #12 should be set to 2L. She further confirmed the tubing for Resident #12 was not labeled. 2. Review of the medical record for Resident #27 revealed an admission date of 01/08/24. Diagnoses included but were not limited to: Unspecified Atrial Flutter; Pain; Rhabdomyolysis, unspecified fall; Essential Hypertension; Unspecified Heart Failure, Chronic Obstructive Pulmonary Disease with Lower Respiratory Infection; Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms; Ventricular Flutter; Malignant Neoplasm of Bladder; Acute on Chronic Diastolic Congestive Heart Failure. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicating intact cognition. The MDS also revealed the resident used oxygen. Review of Resident #27's orders indicated he was ordered oxygen at 3 L via nasal cannula continuous. On 08/19/2025 at 11:44 A.M., Observation of Resident #27 revealed he was on oxygen via nasal cannula. The oxygen flow rate was set to 3.5 Liters (L). Confirmed by RN #30. On 08/19/2025 at 12:05 P.M., RN #30 confirmed the concentrator flow rates for Resident #27 should be 3 L. 3. Review of the medical record for Resident #61 revealed an admission date of 08/13/24. Diagnoses included but were not limited to Sepsis; Unspecified Escherichia Coli; Weakness; Chronic Kidney Disease Stage 3; Alzheimer's Disease; Hyperlipidemia; Myasthenia Gravis without exacerbation; Essential Hypertension; Anxiety; Anemia, and Urinary Tract Infection. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 9 out of 15 indicating moderate impairment. Review of Resident #61's orders indicated she was ordered oxygen on 08/18/25. The oxygen was ordered at 2 L via nasal cannula prn (as needed) to keep O2 (oxygen) sats (saturation) greater than 92%. On 08/18/2025 at 2:32 P.M., Resident #61 was noted to be on Oxygen via nasal cannula. The Oxygen concentrator was set to 3 L. On 08/19/2025 at 11:46 A.M., Observation of Resident #61 revealed an Oxygen concentrator in her room, which was running at a rate of 3L. Confirmed by RN #30 and stated that Resident #61's oxygen should be at 2 L as needed. On 08/19/2025 at 11:58 A.M. an interview with RN #30 revealed the resident's oxygen was managed by the RN on duty. Oxygen tubing was to be changed every Sunday night and labeled with tape to include the date, time, and initials of the RN who changed the tubing. Oxygen flow rate was to be determined by and order from the physician. Review of policy titled Oxygen Administration, dated 03/31/25, revealed Oxygen was to be administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The policy further explained: Oxygen is administered under orders of a physician, except in the case of an (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pataskala Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 144 East Broad Street Pataskala, OH 43062	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency. The policy required the residents care plans to identify the interventions for oxygen therapy, based upon the resident's assessment, which should include the oxygen delivery system, when to administer, such as continuous or intermittent, and when to discontinue. Oxygen saturations were also to be monitored as ordered. Oxygen tubing was to be changed weekly and as needed if became soiled or contaminated.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident observations, policy review, and interviews, the facility failed to assess and implement trauma informed care for two Residents (Residents #5 and #24) of the two residents reviewed for trauma informed care. The facility census was 50. Findings Include: 1. Record review of Resident #24 revealed admission to facility on 03/12/20 with diagnosis including chronic kidney disease, cerebral atherosclerosis (blockage of vessels in the brain), hearing loss of right ear, dysphagia (difficulty swallowing), chronic cough, attention deficit hyperactivity disorder (ADHD), dementia (forgetfulness), diabetes mellitus type II, major depressive disorder, anxiety, mild cognitive impairment of unknown etiology, insomnia (inability to sleep), heart disease, and lung disease. Record review of Resident #24 most recent quarterly Minimum Data Set (MDS 3.0) assessment dated [DATE] revealed no diagnosis of trauma. Record review of Resident #24 most recent psychiatric visit notes by on 02/26/25 revealed no documentation of diagnosis of trauma or trauma related care. Record review of Resident #24 counseling care plan from counseling services with effective date 06/13/25 revealed no history or diagnosis of trauma or trauma focused care. The counseling care plan further revealed diagnosis for treatment including anxiety, dementia with behavioral disturbances, insomnia, low income and depression. Record review of Resident #24 most recent care plan updated on 05/27/25 revealed no specific diagnosis or care plan interventions related to history of trauma or trauma informed care. Several care plans reflected interventions for behaviors related to diagnosis of dementia, ADHD, depression, anxiety, frontotemporal neurocognitive disorder, and impulse control disorder. Interview on 08/18/2025 at 9:10 A.M. with Resident #24 revealed she was raped and had tubal pregnancies as result when she was younger. Resident #24 attributed the rape as why she is having problems with getting urinary tract infections. Resident #24 reported she has been having pain with urination and wanted the nurse to call the doctor. Resident #24 stated I just want the pain to go away, I am up and down all night, and I can't take pain anymore. Resident #24 punched hands into legs and raised her voice to express her frustration. Resident #24 further stated, I drink so much water, and it doesn't help. Resident #24 was crying during interview. Interview on 08/20/2025 at 11:00 A.M. with Registered Nurse (RN) #23 revealed she works as a RN in an as needed capacity and has only been with facility for a couple of months. RN #23 reported Resident #24 sometimes can have behaviors and make sounds as if she is crying but is not actually crying. RN #23 further reported that Resident #24 responded well to praise about her appearance and positive reinforcement. RN #23 reported that Resident #24 has some intellectual impairment and even though elderly her brain was like that of a child at times. RN #23 denied any knowledge of Resident #24 having a history of traumatic events. RN #23 further reported if residents have a known history of depression or are on medications for mental health the facility staff assessed for signs and symptoms of depression daily and reported any behaviors or concerns to the nurse Practitioner. Interview on 08/20/25 at 2:15 P.M. with Social Worker Designee (SWD) #1 revealed she was aware of Resident #24 reporting trauma from being raped as a young girl. SWD #1 reported that Resident #24 is currently getting on site counseling through TBS counseling services and she can see psychiatry (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider if needed. SWD #1 admitted there was no specific screening tool or assessment the facility utilized to assess for Residents with a trauma history. SWD #1 reported the MDS nurse was responsible for establishing care plans for Residents. Interview on 08/20/25 at 3:15 P.M. with the Unit Manager, RN #38 revealed she was aware that Resident #24 has reported being raped as a young girl. RN #38 reported the facility refers Residents to counseling services that are provided on site as need. RN #38 further reported the facility can also make a referral to the psychiatry services if needed for changes in behavior or worsening anxiety and depression symptoms. RN #38 reported that Resident #24 was currently getting counseling services and the MDS coordinator formulated and updated Resident care plans. Interview on 08/20/25 at 3:18 P.M. with the MDS Coordinator, Licensed Practical Nurse (LPN) #62 verified Resident #24's care plans did not include any diagnosis or interventions related to trauma informed care. LPN #62 further revealed she was unaware of Resident #24 having any history of trauma or reporting she was raped as a young girl. LPN #62 reported that she did not have a software template for trauma informed care interventions. Interview on 08/21/25 at 8:00 A.M. with Resident #24 for follow up regarding urinary issues revealed she was still having concerns about pain with urination and repeated that she was raped as a young girl resulting in a pregnancy. 2. Medical record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including nontraumatic chronic subdural hemorrhage, cerebral infarction, diabetes mellitus, major depressive disorder (MDD), anxiety disorder, post-traumatic stress disorder (PTSD), hemiplegia and hemiparesis, and congestive heart failure. Review of the annual Minimum Data Set (MDS) assessment, dated 08/06/25, revealed Resident #5's Brief Interview for Mental Status (BIMS) score was 09 out of 15 , which indicated moderately impaired cognition. This resident was assessed to have a diagnosis of PTSD. Review of the Care Plan for Resident #5 revealed there was not a plan of care in place addressing the cause of PTSD, triggers which may cause re-traumatization, or interventions to reduce the risk of re-traumatization and provide care for PTSD. Further record review for Resident #5 revealed no assessment had been completed to identify the cause of PTSD and to identify potential triggers which may cause re-traumatization. Interview with the Social Services Designee #1 on 08/21/25 at 9:45 A.M. verified an assessment of the cause of PTSD and possible triggers for Resident #76 had not been completed and additionally verified there had not been a plan of care implemented for Resident #5 to minimize the risk of re-traumatization. Record review of the facility policy titled Trauma Informed Care with revised date 03/31/25 revealed trauma events including rape will be addressed by minimizing triggers and/or re-traumatization. The policy further reveals that trauma-specific care plan interventions will recognize the interrelations between trauma and symptoms of trauma.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and policy review, the facility failed to provide proper cleaning/disinfection of equipment between resident use. This affected two (Resident #32 and #12) of eight residents (Resident #5, Resident #9, Resident #12, Resident #27, Resident #32, Resident #34, Resident #45, and Resident #61) identified on Middle Hall as requiring blood pressures prior to medication administration and one (Resident #19) of one reviewed for glucometer use. The facility census was 50. Findings Include: 1. On 08/20/2025 at 8:16 A.M., observation revealed Registered Nurse (RN) #33 took Resident #32's blood pressure using an electronic blood pressure monitor. She did not sanitize the blood pressure cuff at that time. RN #33 then completed the medication administration of this resident. On 08/20/2025 at 8:39 A.M., observation revealed RN #33 take Resident #12's blood pressure with an electronic wrist blood pressure monitor. This was the same cuff used on Resident #32 and was not cleaned between residents. On 08/20/25 at 8:45 A.M., an interview with RN #33 revealed she did not sanitize the digital blood pressure monitor between uses. This included not sanitizing the monitor prior to use on Resident #32, before use on Resident #12, or after use on Resident #12. Review of the user guide for Dynarex Digital Blood Pressure Monitor indicated the machine should be cleaned with a soft, dry cloth. Further instructions were do not use petrol, thinners or similar solvent. Spots on the cuff could be removed carefully with a damp cloth and soapsuds. 2. Review of medical record of Resident #19 revealed admission to facility on 05/23/23 for diagnosis including hemiplegia (loss of limbs use of one side) and hemiparesis (loss of feeling limbs of one side) following a stroke, diabetes mellitus type II, chronic kidney disease, heart disease, and chronic ulcer of right lower leg. Review of Order Summary dated 08/21/25 of Resident #19 revealed orders for blood glucose checks four times a day. The Order Summary further revealed Resident #19 was ordered a FreeStyle Libre 2 Plus Sensor on 08/20/25 and to start use on 08/21/25. Observation on 08/21/25 at 11:30 A.M. revealed Registered Nurse (RN) #33 was cleaning the Assure Prism Glucometer with an alcohol wipe for less than one minute and then immediately returned to drawer in the medication cart while the glucometer was still wet. Interview on 08/21/25 with RN #33 revealed the process for cleaning the glucometer included wiping the glucometer with either alcohol or with Sani-Cloth Bleach Wipes (EPA #9480-8). She reported this was what she was instructed to do. When RN #33 was asked about wet time for Sani-Cloth Bleach Wipes and she could not answer, but Licensed Practical Nurse (LPN) #34, who was also present stated 5 minutes. Verified with LPN #34 and RN #33 the wet time per manufacture specified on the Sani-Cloth Bleach Wipes box was 4 minutes. RN #33 reported that she believed the wet time for the alcohol wipe was 5 minutes. LPN #34 was in agreement with 5 minutes. RN #33 verified that she had cleansed the glucometer with only one alcohol wipe and placed it back in drawer immediately without (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allowing to dry or ensuring wet time of 5 minutes. Interview on 08/21/25 with RN #33 verified the glucometer being used was for the medication cart assigned to Residents in room numbers 17, 18, and 19. RN #33 verified currently Resident #19 in room [ROOM NUMBER] was the only Resident utilizing the specified glucometer and that a personal FreeStyle Libre 2 Plus Sensor had been ordered for Resident #19 to monitor blood glucose but has not yet arrived. RN #33 verified Resident #19 currently had no diagnosis of blood borne pathogen diseases such as Hepatitis B or C or HIV. Review of the Assure Prism Multi glucometer manufacture's guidelines for cleaning and disinfecting revealed when the glucometer was used for multiple residents the following cleaning procedure should be followed: Each time the cleaning and disinfecting procedure is performed, two wipes are needed; one wipe to clean the meter and a second wipe to disinfect the meter. Always wear the appropriate protective gear, including disposable gloves. Open disinfectant package and pull out one towelette. Squeeze any excess liquid out of the towelette. Wipe the entire surface of the meter using the towelette at least three times vertically and three times horizontally to clean blood and other body fluids from meter. Dispose of the towelette. Repeat above steps with a new towelette to disinfect the meter. Meter surfaces must remain wet according to contact times listed in the wipe manufacturer's instructions. Once complete, wipe meter dry. Use caution so as to not allow moisture to enter the test strip port, data port or battery compartment, as it may damage the meter. Review of Assure Prism Multi glucometer manufacture's guidelines for cleaning and disinfecting further revealed, Only wipes with the Environmental Protection Agency (EPA) registration numbers listed below have been validated for use in cleaning and disinfecting the meter. Any disinfectant product containing these EPA registration numbers may be used on this device. These EPA registration numbers can be found on the EPA website. Wipes with EPA registrations numbers not listed below should not be used to clean and disinfect the Assure Prism meter. The products listed are Clorox Germicidal Wipes (EPA #67619-12, Clorox Dispatch Hospital Cleaner Disinfectant Towels with Bleach (EPA # 56392-8), Super Sani-Cloth Germicidal Disposable Wipe (EPA # 9480-4), and CaviWipes1 (EPA #46781-13). Review of a policy titled Cleaning and Disinfection of Resident-Care Equipment, dated 03/31/25, revealed Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations to break the chain of infection. The policy referred to a Reusable multiple-resident item as items that may be used multiple times for multiple residents. Examples include stethoscopes, blood pressure cuffs, feeding tube pumps, and oxygen concentrators. The policy explanation and Compliance Guidelines for cleaning and disinfection further revealed staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. These guidelines should include: Verifying whether the equipment was single-use or reusable and discarding single-use items after use; Each user was responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident; and multiple-resident use equipment should be cleaned and disinfected after each use. Gloves should be worn when cleaning/disinfecting equipment, and staff should follow the manufacturer recommendations for cleaning equipment.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to maintain an effective antibiotic stewardship program by not ensuring a resident was not started on an antibiotic for a suspected urinary tract infection until a urinalysis culture result was received to identify best course of treatment. This affected one (Resident #8) of four residents reviewed for urinary tract infections. The facility census was 50. Findings include: Review of Resident #8's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included schizophrenia, psychotic disorder with delusions, dementia, and the need for assistance with personal care. Review of Resident #8's nurses' progress notes revealed a nurse's note dated 06/04/25 at 3:13 P.M. that indicated the resident was seen by the nurse practitioner that day for increased confusion and weakness. She was previously ordered to have laboratory test performed to included a complete blood count and a complete metabolic panel, but had refused to have the lab drawn. A new order was to dip the resident's urine and to send it for a urinalysis and culture and sensitivity (U/A C&S) if positive. Her urine was dipped on 06/04/25 at 4:41 P.M. and was positive for leukocytes (white blood cells), protein, and blood. Her urine was collected and placed in lab refrigerator awaiting pick up. The nurse practitioner was notified and a new order was received to start the resident on Macrobid 100 milligrams (mg) by mouth twice a day for seven days for a urinary tract infection (UTI). Further review of Resident #8's nurses' progress notes revealed a nurse's note dated 06/09/25 at 4:30 P.M. that indicated the U/A C&S results were received. The nurse practitioner was in the facility and reviewed the results. She gave a new order to discontinue the resident's Macrobid and start Cipro 500 mg twice a day for seven days to treat her UTI. Review of the U/A C&S results for the urinalysis that was collected on 06/06/25 revealed Resident #8 had greater than 100,000 colonies/ milliliter of Klebsiella Pneumoniae in her urine indicative of a UTI. The susceptibility report showed Klebsiella Pneumoniae was only intermediate susceptible to Macrobid (the first antibiotic ordered), which meant the antibiotic might be effective at a higher or more frequent dose, but not as reliable as one of the susceptible results like Cipro (the second antibiotic ordered for the resident). On 08/21/25 at 1:40 P.M., an interview with the Director of Nursing (DON) confirmed Resident #8 was started on Macrobid for the treatment of a UTI on 06/04/25, prior to them receiving the final culture results. She further confirmed Resident #8's antibiotic had to be changed from Macrobid to Cipro on 06/09/25, after the culture results showed the organism causing the infection was more susceptible to Cipro than it was to the previous antibiotic ordered. She acknowledged antibiotics should not be initiated, until after the culture report was available identifying the the organism causing the infection, so an appropriate antibiotic could be ordered to properly treat the infection. She further acknowledged the resident was only given a partial course of the first antibiotic ordered, which could contribute to the identified organism being more resistant to the antibiotic. She was not able to provide any evidence of the resident having a history of sepsis, which may have supported the advanced level providers decision to go ahead and start the resident on an antibiotic out of precaution before the culture and sensitivity results were available. Review of the facility's Antibiotic Stewardship policy (not dated) revealed it was the policy of the facility to implement an antibiotic stewardship program as part of the facility's overall infection prevention and control program. The purpose of the program was to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The DON was responsible for establishing standards for nursing staff to assess, monitor, and communicate changes in a resident's condition that could impact the need for antibiotics, use their influence as nurse leaders to help ensure antibiotics were prescribed only when appropriate, and educate front line nursing staff about the importance of antibiotic stewardship and explain policies in place to improve antibiotic use. Antibiotic orders obtained from consulting providers should be reviewed for appropriateness.		