STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366051	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Northpointe	3291 Northpointe Drive Zanesville, OH 43701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of self-reported incident (SRI), review of the facility investigation, interview, and policy review the facility failed to ensure all allegations of resident abuse was reported immediately to the administrator and to the state survey agency. This affected two residents (#66, #70) of four residents reviewed for abuse. Findings included: Review of Resident #70's medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, dementia, mood disorder, paranoid personality disorder, delusional, depression, anxiety, and hypertension. The resident resided on the secure unit. Review of Resident #66's medical record revealed Resident #66 was admitted to the facility on [DATE] with diagnoses including heart failure, dementia, diabetes, kidney disease, dementia, and depression. The resident resided on the secure unit, however, was a previous resident of the attached Assisted Living (AL). Review of the SRI 260860 dated 05/27/25 (four days after the incident) revealed on 05/23/25 staff heard yelling coming from Resident #66's room. Upon entering the room, Resident #70 was noted sitting upright on buttocks with Resident #66 standing over her. Resident #66 informed staff that she wouldn't leave my room, so she pushed her down. Residents were separated and redirected. Resident #66 was able to provide meaningful information. Resident #70 was not able to provide meaningful information due to severe cognition impairment. Review of the facility's investigation revealed a progress note dated 05/23/25 from Resident #66's medical record that indicated on 05/23/25 at 4:00 P.M., Certified Nursing Assistant (CNA) #125 come out of from the secured unit to the assisting living (AL) where (medication technician (MT) #107) was passing medication and told her there was an altercation between two residents (#66 and #70). Resident #70 had walked into Resident #66's room. Resident #66 screamed at Resident #70 and told her to get out and pushed Resident #70 to the floor. Resident #70 was not hurt. MT #107 told the staff to do 15-minute checks on Resident #70 and do an incident report plus vitals since it was unwitnessed, but there wasn't a whole lot she could do since she couldn't do skilled charting, etc., and she would turn it over to the night shift nurse tonight. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Certified Nursing Assistant (CNA) #125's typed statement dated 05/27/25 revealed the incident occurred right before dinner. Prior to the incident Resident #66 was in the dining room and said she had to go to her room and proceeded to go there. Resident #70 was last seen walking the halls and was noted to walk towards the top of the hall, the general area of Resident #66's room. Resident #70 had her gripper socks on because she kept removing her shoes. CNA #125 reported she was in the dining room when she heard yelling coming from Resident #66's room. Resident #66 was yelling get the hell out of my room! The CNA ran into Resident #66's room and saw Resident #70 sitting upright on her buttocks in front of the bathroom door with Resident #66 standing over her. Resident #66 reported she wouldn't leave my room, so I pushed her down. The Velcro stop sign was not present on Resident #66's room because she keeps removing it and packing it into her things. Review of Registered Nurse (RN) #302's typed statement dated 05/31/25 revealed she was not notified of any resident incidents on 05/23/25. Review of CNA #167's typed statement dated 05/29/25 revealed the CNA was in the dining room waiting for dinner to arrive. The CNA heard someone yelling out from Resident #66's room. The CNA ran to Resident #66 room with CNA #125 and Resident #70 was on the floor in front of the bathroom sitting on her butt with Resident #66 standing over her. Resident #70 was not able to provide meaningful information about the incident. The CNA's checked her skin and assisted her off the floor. Resident #70 complained that her left elbow was hurting but no skin issues noted. Resident #66 reported the resident wouldn't leave her room, so she pushed her down. The residents were separated, and Resident #66 remained in her room. CNA #125 went to the Assisted Living to get MT #107. MT #107 came to the unit, and the CNA's gave MT the update. CNA #167 reported she thought MT #107 was a nurse. Review of MT's #107 typed statement dated 06/02/25 revealed an aide had stuck her head out of the secure unit and said, Hey I need you. The MT #107 went back and was told that Resident #66 had pushed the other resident down. Resident #66 was yelling and pacing trying to get out of the unit. MT #107 tried to re-direct her, but she kept yelling at me. Resident #70 was already up and sitting on the couch. Resident #66 was yelling at the staff and following them. Directed the aides to do 15-minute checks and monitor her vital signs. Review of Licensed Practical Nurse (LPN) #117's typed statement dated 05/30/25 revealed she was not notified of any resident-to-resident altercation on 05/23/25 and was unaware of the incident. Review of Resident #66's social service note dated 05/28/25 and 05/29/25 revealed Resident #66 remained remorseful for her actions when asked about the incident with the other resident. Further review of the SRI investigation revealed no evidence of 15-minute checks and vital signs being obtained for Resident #70 per the direction of MT #107. Review of Resident #70's medical record revealed no evidence Resident #70 as assessed by the nurse or the physician or families were notified of the incident that occurred on 05/23/25 until 05/27/25. Interview on 06/04/25 at 11:50 A.M. with the Administrator revealed she was not notified of the physical abuse allegation until 05/27/25. The two caregivers had notified the medication tech and there was some confusion on who was going to notify the Administrator. The Administrator reported staff were provided education on the abuse policy. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/09/25 at 7:28 A.M., with the Director of Nursing (DON) confirmed Resident #66 had admitted to pushing Resident #70 down due to Resident #70 would not leave her room. The DON confirmed the incident occurred on 05/23/25, however it was not discovered until 05/27/25. The DON confirmed there was no evidence in the SRI investigation or medical record that 15 minute checks, neurological exam, or vital signs were obtained for Resident #70 on 05/23/25, there was no evidence Resident #70 was assessed by a licensed nurse until 05/27/25 and the resident had voiced complaints of arm pain after the incident. The DON also confirmed there was there documented evidence the family or physician was notified on 05/23/25 of the resident to resident incident until 05/27/25. Interview on 06/09/25 at 8:50 A.M., with the DON revealed she had just found 15-minute checks and some vital signs undated in her mailbox for Resident #70. The DON confirmed she didn't know they existed or where they came from until this morning when she found them in her mailbox. The DON confirmed the fall investigation, neurological assessments, notification, and investigation was not initiated on 05/27/25 when the incident was discovered. Review of the facility's Abuse policy (undated) revealed every resident has the right to be free from verbal, sexual, physical, and mental abuse and was strictly prohibited. It is the responsibility of employees to immediately report to the facility administrator, and to other officials in accordance with Federal and State law, and incident of suspected or alleged abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. All employees under the law must report to the state survey agency and at least one local law enforcement entity any reasonable suspicion of a crime committed against a resident or a person receiving care from the facility, within the required timeframe. In response to allegations of abuse the facility would ensure that all alleged violations are reported immediately, but not later than two hours after the allegation is made, in accordance with state and federal laws. There was additional box under reporting that included: -You must report allegations, even if you believe false when first reported to you. -Dementia resident allegation should be taken equally as serious; do not just dismiss these concerns. -You MUST report this to your Administrator IMMEDIATELY. -Immediate means NOW, not at the end of your shift. -It is everyone's responsibility to report allegations and concerns of abuse, neglect, misappropriation, and exploitation. -We have two hours to report an allegation to the state agency. Your timeliness is critical to safety and a complete investigation. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00165582.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a self-reported incident (SRI) and investigation, and interview the facility failed to ensure a dependent resident was provided adequate oral hygiene. This affected one resident (#36) of one resident reviewed for neglect. Findings included: Review of Resident #36's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including need for assistance with personal care, lack of coordination, dysphagia, and degenerative disease of the nervous system. Review of Resident #36's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognition impairment. The resident had no rejection of care behaviors. It was very important to have her family involved in discussions about her care. The resident had functional limitation of range of motion on one side of the upper extremity and both sides on lower extremity. The resident required substantial/maximal (helper does more than half of the effort) for oral hygiene. The resident had no obvious or likely cavity or broken natural teeth, no inflamed or bleeding gums or loose natural teeth, no mouth or facial pain, and no abnormal mouth tissue. Review of Resident #36's current plan of care (the facility changed ownership in December 2024 and switched electronic medical records (EMR) and the start date on all the care plans was February 2025) revealed the resident was at risk for fluid volume deficit/imbalance related to diuretic use. Interventions were to monitor and report sign and symptoms of dehydration including furrowed tongue, thirst, and cracked lips. Offer fluids of choice. The resident preferences via family request plan of care dated 02/21/25 revealed morning and evening routine: brush teeth. Encourage water to keep her hydrated and cut down on urinary tract infections. She prefers it with flavoring located in her room. The resident was at risk for dental problems related to natural teeth, risk for poor dentition related to assistance needs care plan dated 02/20/25 and revised 05/28/25 revealed assess condition of oral cavity , teeth, tongue and lips. Provide oral hygiene at least once daily Provide assistance as needed. The resident had an activity of daily living (ADL) self-care performance deficit related to anxiety, cognitive impairment, depression, fluctuating ADLs, functional limitation in range of motion, generalized weakness, intellectual disabilities, pain, right sided weakness, wheelchair for mobility, and the resident is deaf and requires staff to speak directly in front of her as she is able to read lips. ADL's fluctuate related to behaviors and weakness. The interventions included to assist with ADL's including oral care. The resident had impaired neurological status related to intellectual disability and/or developmental disability care plan dated 02/21/25 revealed to assist resident with normal daily task as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident concern form dated 03/05/25 revealed Resident #36's family had concerns mouthwash was not being used, laundry, and resident was not put in recliner today. The family member was upset. The Director of Nursing (DON) was notified of mouth care and recliner. To ensure the situation doesn't occur again staff were to put out updated residents preferences. The resolution communicated to family was staff was educated on chair and list put at nurses station and will check daily for clothes to be passed. There was no documented evidence mouth care concern was addressed. Review of dental note (facility dentist) dated 10/17/24 revealed the resident had no pain and ate fine. Restorative tooth charting updated. Oral hygiene instruction provided and x-rays taken. There was no documented evidence of the tooth charting. Review of Resident #36's progress note dated 04/17/25 and 04/18/25 revealed the Nurse Practitioner (NP) assessed resident and no dental abscess noted, family updated, and will continue on dental list for next visit. There was no documented evidence of the NP visit in the electronic medical record. Review of dental note (facility dentist) dated 04/30/25 revealed Tooth #3, #4, #5, #8, #9, #28, and #29 had decay and #2 and #17 were on watch. The resident reported pain on lower left and pointed at Tooth #17. Tooth #17 was difficult to assess but noticed slight decay. Referred to oral surgeon for extraction of Tooth #1, #2, and #17. Poor oral hygiene. Instructions given on brushing any dentition, tongue, tissue along with rinsing and or swabbing mouth out daily to decrease bacteria. The resident had moderate calculus and heavy plaque. Scaling was completed by hand, polishing of coronal services was completed. Recommendation-assistance from staff for daily hygiene. Silver [NAME] fluoride silver diamine fluoride (SDF) has been applied to lower right an upper right anterior areas to arrest decay and prevent further decay from appearing. Review of a dental note (outside dental office) dated 05/07/25 revealed Resident #36 was seen in the office for a comprehensive dental examination on 05/27/25. The resident exhibited extremely heavy plaque buildup, leading to plaque-induced gingivitis and pain. It appears the patient has not been getting adequate home care due to severity of plaque buildup seen today in the office. Our recommendation is that resident was to have teeth brushed at least once per day (ideally, twice a day) to ensure adequate plaque removal, or her gingival condition could worsen. The resident also has some untreated dental needs, such as need for extraction of a heavily-decayed molar in upper right. We have referred the resident to a clinic for treatment due to her extensive medical history. Review of Resident #36's sister statement dated 05/28/25 revealed she had went to the dentist with her sister yesterday and he said the resident's mouth issues were nothing less than negligence. He asked if the resident lived in a nursing home, and the sister said yes, the resident did. Per the resident's sister statement, the dentist said yea that is the problem with all nursing homes. Review of SRI 260967 dated 05/28/25 revealed Resident #36 was seen by the dentist on 05/27/25. Family reported on 05/28/25 during a resident care conference that dentist informed them that plaque on teeth was a result of neglect. Immediate intervention was oral care, continue current order for Tylenol and the resident was assessed for pain and indicated 0/10 on the pain scale. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility documentation revealed Resident #36 was seen by an oral surgeon on 05/27/25. Resident #36's sister reported on 05/28/25 during a resident care conference that dentist informed them that plaque on teeth was a result of neglect. After reviewing notes from 05/27/25 appointment from the oral surgeon the resident was noted with heavy plaque buildup. The note went on to say it appears the resident has not been getting adequate home care due to severity of plaque buildup seen today in the office. Resident noted with routine dental care from 360 Care on 4/30/25, 10/17/24, 3/26/24 and 9/22/23. All visit notes leading up to the 4/30/25 dental visit did not mention concerns with plaque build-up or need for future referrals/care. On the 4/30/25 visit, resident noted with plaque and need for additional dental work. Referral was sent to oral surgeon with appointment date of 05/27/25. Upon review of family concerns, x 1 concern noted in regards to mouthwash not being used. No complaints of oral care not being provided. Careplan noted to encourage resident to complete oral hygiene at least daily. Upon POC review, resident noted to receive oral care daily almost all days through April and May (2025). Those residents that are interviewable were. All residents denied dental concerns. Resident unable to complete interview has an oral assessment completed with no major concerns requiring dental referral. Immediate intervention: oral care, continue current order for Tylenol and assessed for pain and indicated 0/10 on the pain scale. Review of the SRI disposition revealed the SRI was unsubstantiated due to evidence indicates abuse, neglect or misappropriation did NOT occur. Those residents that were interviewable were. All residents denied dental concerns. Resident unable to complete interview has an oral assessment completed with no major concerns requiring dental referral. On going audit/interviews completed. Review of Resident #36's Nurse Practitioner (NP) note dated 06/09/25 revealed on 04/17/25 the resident was seen for acute visit for dental pain. Nursing reports family noticed that the resident appeared to be in pain when eating. Nursing does not report any signs or symptoms of pain. Requested evaluation for possible abscess. Resident was eating and drinking as usual. No new mood changes or behavioral concerns noted. Reviewed vitals, medication list, orders, and nursing notes for additional information. Unable to obtain full review of system due to cognitive impairment. Denies' mouth pain when asked. The resident is deaf and smiles when asked. A cotton tipped applicator was used to examine gums, no abscess or bleeding of gum line noted. Breathing easy on room air. Continue with supportive care. Interview on 06/04/25 at 1:41 P.M., with Licensed Practical Nurse (LPN) #179 confirmed there had been some families including Resident #36's family that has concerns with oral hygiene not being performed frequently. Interview on 06/04/25 at 2:35 P.M. with the Administrator revealed Resident #36 had no dental issues in October 2024 per the dental note, however in April (2025) the facility dentist noted issues and referred the resident to outside dentist. The resident saw the outside dentist a month later (05/27/25) and documented poor oral care and cavities and referred to another dentist, which the facility was working on an appointment. The Administrator reported staff were documenting they were providing oral care. She could not confirm why the resident's teeth were in poor condition in the last six months. The resident was mostly dependent of staff for oral care. Resident #36's sister had reported concerns in March (2025) regarding mouth wash not being used due to she had marked the bottle and noticed staff were not using it. Interview on 06/04/25 at 3:00 P.M. with the Administrator reported oral care should be done at least once daily. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/25 between 7:00 A.M. and 3:00 P.M. with anonymous Staff Member #303 confirmed oral hygiene was not being performed as frequently as it should to residents and there had been concerns reported to management. This deficiency represents non-compliance investigated under Complaint Number OH00165582.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 medical record review, review of self-reported incident (SRI), review of the facility's investigation, interview, and policy review the facility failed to timely assess, monitor, and report weight gain. This affected one resident (#70) of three residents reviewed for falls and one resident (#20) three residents reviewed nutrition. Findings included: 1. Review of Resident #70's medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, dementia, mood disorder, paranoid personality disorder, delusional, depression, anxiety, and hypertension. The resident resided on the secure unit. Review of the SRI 260860 dated 05/27/25 (four days after the incident) revealed on 05/23/25 staff heard yelling coming from Resident #66's room. Upon entering the room, Resident #70 was noted sitting upright on buttocks with Resident #66 standing over her. Resident #66 informed staff that Resident #70 wouldn't leave her room, so she pushed Resident #70 down. Residents were separated and redirected. Resident #66 was able to provide meaningful information. Resident #70 was not able to provide meaningful information due to severe cognition impairment. Review of certified nurse aide (CNA) #167's typed statement dated 05/29/25 revealed the CNA was in the dining room waiting for dinner to arrive. The CNA heard someone yelling out from Resident #66 room. The CNA ran to Resident #66's room with CNA #125 and Resident #70 was on the floor in front of the bathroom sitting on her butt with Resident #66 standing over her. Resident #70 was not able to provide meaningful information about the incident. The CNA's checked her skin and assisted her off the floor. Resident #70 complained that her left elbow was hurting but no skin issues noted. CNA #125 went to the Assisted Living to get Medication Tech (MT) #107. MT #107 came to the unit, and the CNA's gave MT the update. CNA #167 reported she thought MT #107 was a nurse. Review of MT #107 typed statement dated 06/02/25 revealed she directed the aides to do 15-minute checks and monitor the resident's vital signs. Review of Licensed Practical Nurse (LPN) #117 typed statement dated 05/30/25 revealed she was not notified of any resident-to-resident altercation on 05/23/25 and was unaware of the incident. Further review of the SRI investigation revealed no evidence of 15-minute checks and vital signs were obtained for Resident #70 per the direction of MT #107. Review of Resident #70's medical record revealed no evidence Resident #70 was assessed by the nurse regarding the incident that occurred on 05/23/25 until 05/27/25. Review of the facility's policy titled Falls dated 09/2021 revealed no evidence of policy or procedure on what to do if a fall occurs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/09/25 at 7:28 A.M., with the Director of Nursing (DON) confirmed Resident #66 had admitted to pushing Resident #70 down due to Resident #70 would not leave her room. The DON confirmed the incident occurred on 05/23/25, however it was not discovered until 05/27/25. The DON confirmed there was no evidence in the SRI investigation or medical record that a physical assessment was completed by a licensed nurse, 15-minute checks, neurological exam, or vital signs were obtained for Resident #70 on 05/23/25, there was no evidence Resident #70 was assessed by a licensed nurse until 05/27/25 and the resident had voiced complaints of arm pain after the incident. Interview on 06/09/25 at 8:50 A.M., with the DON revealed she had just found 15-minute checks and some vital signs undated in her mailbox for Resident #70. The DON confirmed she didn't know they existed or where they came from until this morning when she found them in her mailbox. The DON confirmed the fall investigation, neurological assessments, and investigation was not initiated until 05/27/25 when the incident was discovered. Interview on 06/09/25 at 10:14 A.M., with the DON revealed the facility did not have a policy or procedure for staff to follow when a fall occurred. The DON reported she provided education when she trains new staff on what needs documented and what forms need to be completed. The DON reported that if Agency staff were working and an incident (fall, medication error, etc.) occurs she instructs the Agency staff member to call her and she would walk the staff member through to ensure all forms, documentation, and notification were completed. 2. Medical record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including edema, heart failure, diabetes, anemia, and cirrhosis of the liver. Review of Resident #20's current orders dated 06/2025 revealed on 11/28/24 the resident received orders for daily weights and to call physician if there was two-pound weight gain in 24 hours or five-pound weight gain in a week. Review of Resident #20's impaired cardiovascular plan of care dated 01/22/25 revealed to monitor weights as ordered. Review of Resident #20's impaired hepatic function related to cirrhosis plan of care dated 01/22/25 revealed to report to provider signs or symptoms of complications (increased edema, ascites, significant weight gain). Review of Resident #20's treatment administration record (TAR) dated 05/2025 revealed to weigh resident daily and call if weight gain of two pounds in 24 hours and five pounds in one week. Further review revealed no documented evidence the resident was weighed on 05/03/25, 05/19/25, 05/22/25, 05/26/25, 05/27/25, 05/29/25, and 05/30/25. Further review revealed on 05/14/25 the resident weighed 243 and on 05/15/25 he weighed 245.4 which was a 2.4-pound weight gain. On 05/18/25 the resident weighed 244.6, he was not weighed on 05/19/25, and 05/20/25 he weighed 246.6, which was a two-pound weight gain from previous weight. Review of Resident #20's weights in the electronic medical record revealed no evidence the resident was weighed on 05/03/25, 05/19/25, 05/22/25, 05/26/25, 05/27/25, 05/29/25, and 05/30/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's progress notes revealed no evidence the resident had refused weights, no evidence the resident was weighed on 05/03/25, 05/19/25, 05/22/25, 05/26/25, 05/27/25, 05/29/25, and 05/30/25, nor was there evidence the provider was notified of more than two-pound weight gain on 05/15/25 or 05/20/25 per orders. Interview on 06/09/25 at 9:10 A.M., with the DON confirmed there was no documented evidence the resident was weighed on 05/03/25, 05/19/25, 05/22/26/25, 05/27/25, 05/29/25, and 05/30/25 nor evidence the resident provider was notified of two-pound weight gain on 05/15/25 or 05/20/25. The DON reported the resident weighs himself; however, it was the nurse's responsibility to ensure the weights were obtained, documented, and reported to the provider per orders. Interview on 06/09/25 at 9:32 A.M. with Resident #20 along with the DON revealed the resident doesn't keep track of his own weights. The resident reported he gets weighed daily and he has to have staff help due to once you stand up from the scales the weight goes away, and he can't see the weight. The resident reported it was difficult to find working scales, and he has to go to several units until he can find a scale that works. This deficiency represents non-compliance investigated under Complaint Number OH00165582.

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Oaks at Northpointe	3291 Northpointe Drive Zanesville, OH 43701

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital notes, review of wound clinic notes, and interviews, the facility failed to comprehensively assess and provide treatment as ordered to a resident foot. This affected one resident (#2) of three residents reviewed for skin alterations. Findings included: Medical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including heart failure, cellulitis, diabetes, protein-calorie malnutrition, immunodeficiency, breast cancer, venous insufficiency, and pulmonary hypertension. Review of Resident #2's hospital skin assessment dated [DATE] revealed the resident had a wound on bottom left great toe that measured 1.0 centimeter (cm) by 0.8 cm and unable to determine depth (UTD) with scant sanguineous drainage. The wound bed was dry, red, and crusted with sanguineous drainage. The peri-wound was calloused, red, and purple and the margins were irregular shaped with a purple rim noted. Review of Resident #2's hospital orders dated 04/29/25 revealed to cleanse wound on great toe with normal saline, apply therahoney gel (promotes autolytic debridement) , cover with two-by-two gauze and secure with tape daily. Review of Resident #2's admission assessment revealed the resident had a wound on the left great toe. There was no documented evidence of a comprehensive assessment to include size or characteristics of the wound. Further review revealed no evidence that an assessment of the wound was completed from 05/04/25 to 05/20/25. Review of Resident #4's treatment administration record (TAR) and orders dated 05/2025 revealed the treatment to the left great toe was not ordered until 05/08/25 (four days after admission). The order was to cleanse the bottom of the left great toe daily and apply medihoney and non-adherent dressing daily and as needed. Further review of the TAR from 05/08/25 to 05/19/25 revealed no documented evidence the treatment was completed on 05/09/25, 05/11/25, 05/13/25, 05/17/25, 05/18/25, and 05/19/25. Review of the wound clinic note dated 05/19/25 revealed the resident had a diabetic ulcer to the left great toe measured 1.5 cm by 1.5 cm by UTD. The wound bed was eschar and dry. The peri-wound was dry and flaky, and margins were calloused. The toe wound was debrided and new treatment order to apply Aquacel AG (anti-microbial dressing) to wound bed, cover with dry gauze, secure with two inch conform daily. Review of Resident #2's wound evaluation note dated 05/20/25 revealed the resident had a diabetic ulcer on the left great toe that measured 1.5 cm by 1.5 cm by UTD. The wound bed assessment was blank, and the peri wound appearance was dry and flaky. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's wound evaluation note dated 05/27/25 revealed the resident had a diabetic ulcer on the left great toe that measured 1.5 cm by 1.5 cm by UTD. The wound bed assessment was blank, and the peri wound appearance was dry and flaky. Review of Resident #2's wound evaluation note dated 06/03/25 revealed the resident had a diabetic ulcer on the left great toe that measured 1.5 cm by 1.3 cm by UTD. The wound bed assessment was blank, and the peri wound appearance was dry and flaky. Review of the TAR dated 05/19/25 to 06/05//25 revealed the new order for Aquacel AG from the wound center dated 05/19/25 was not initiated until 05/21/25. The previous order for the medihoney was not discontinued and staff were administering both treatments until 06/05/25. Review of the wound clinic note dated 06/04/25 revealed the left great toe measured 1.0 cm by 1.1 cm by UTD. The wound bed was eschar and dry. The peri-wound was dry and flaky, and margins was calloused. The toe wound was debrided and new treatment order to apply Aquacel AG to wound bed, cover with dry gauze, secure with two inch conform daily. Interview on 06/09/25 at 3:06 P.M., with Resident #2 revealed there was not sufficient staff to administer medication and treatments timely. The resident reported that she doesn't get treatment done daily to left great toe as ordered. When she went to the wound clinic last week the doctor was upset because there was no dressing at all on her toe. Interview on 06/10/25 at 2:36 P.M., with the Assistant Director of Nursing (ADON) #146 confirmed the resident was admitted on [DATE] however there was no comprehensive assessment of the left great toe wound on admission. The ADON confirmed a treatment was not implemented until 05/08/25 (four days after admission). The DON confirmed there was no documented evidence treatments were completed on 05/09/25, 05/11/25, 05/13/25, 05/17/25, 05/18/25, and 05/19/25. The ADON confirmed the wound center had changed the treatment on 05/19/25 however the facility did not implement the new treatment (Aquacel) until 05/21/25 and the staff did not discontinue the previous treatment (medihoney) and was documenting they were performing both treatments from 05/21/25 to 06/05/25. The ADON also confirmed there was no weekly assessment completed from admission [DATE] until she returned from leave on 05/20/25. The ADON reported she was the facility's wound nurse; however, she was off from 04/18/25 to 05/19/25. The ADON reported she was not wound certified; however she had some training, and the facility just hired a company to come in weekly to help assist with wound care. This deficiency represents non-compliance investigated under Complaint Number OH00165582.

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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. Based on observation, interviews and record review the facility failed to ensure safety measures were implemented to prevent resident injuries. This affected one resident (#34) of three residents reviewed for accidents. Findings Include: Review of the medical record for Resident #34 revealed an admission date 08/07/24. Diagnoses included diabetes mellitus, respiratory failure with hypoxia, chronic kidney disease, heart failure, dysphagia, and other feeding difficulties. Review of the physician orders dated 06/10/25 revealed wound care for left leg to be cleansed with normal saline, apply skin prep and leave upon to air. Monitor steri strips and allow them to fall off on their own. Review of the wound evaluation dated 12/10/24 revealed new skin tear to right lateral calf noted measuring 3. 4 centimeter (cm) by 2.8 cm by 0.2 cm. Resident #34 reported the night before the leg piece of the wheelchair hit her leg. The intervention was to pad the leg rest on the wheelchair. Review of the progress note dated 12/10/24 at 9:34 A.M. revealed new skin tear to right lateral calf noted. Resident #34 reported it happened last night on the leg piece of the wheelchair. On 01/02/25 the Inter Disciplinary Team met in regards to a new skin tear to posterior right calf after being transferred to bed. Will add wheelchair leg attachments when transferring resident. On 04/08/25 at 7:20 P.M. revealed Resident #34 transferring with aide and the wheelchair caught on back of leg, causing a skin tear on left back leg area. On 06/05/25 at 8:37 A.M. it was revealed Resident 34 was being assisted into bed when her left calf was bumped by her wheelchair footrest causing a two-inch skin tear, steri stripes were applied and area was wrapped. Review of the plan of care dated 12/10/24 for impaired skin integrity related to fragile skin at risk for skin tears, assistance needed for mobility, transfers and toileting. Interventions included encourage good nutrition and hydration, pad wheelchair leg piece and encourage Resident #34 to wear long pants. Interview on 06/10/25 at 10:56 A.M. with Resident #34's daughter revealed Resident #34 continues to receive skin tears to her lower legs because when staff are transferring her they hit her legs on the leg rests causing multiply skin tears. Resident #34's daughter stated the facility was supposed to pad the leg rests so her mother would not receive new skin tears, and they have not padded the wheelchair leg rests yet. She also stated she brought in pool noodles to be put over the bed frame to help with not receiving new skin tears and they have yet to put them on the bed. Interview on 06/11/25 at 8:50 A.M. with Resident #34 revealed she just got another skin tear on her left calf from hitting the wheelchair when staff are transferring her. Resident #34 stated they were supposed to cover her wheelchair leg rests and they have not. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/11/25 at 10:40 A.M. of Resident #34 revealed she was up in her wheelchair; she had long pants on and a short sleeve shirt. Observation of her wheelchair revealed no padding around the leg rests. Interview on 06/11/25 at 10:44 A.M. with Licensed Practical Nurse (LPN) #199 stated Resident #34's got a new wheelchair on 06/10/25 and verified there is no order for the wheelchair leg rest to be padded. LPN #199 verified Resident #34 does receive skin tears from the footrests on her wheelchair. Interview on 06/11/25 at 10:47 A.M. with Certified Nurse Assistant (CNA) #151 and #184 stated the old wheelchair leg rests were not padded and the new wheelchair does not have any padding on the leg rests. Observation on 06/11/25 at 11:00 A.M. of Resident #34's old wheelchair that was in the social services office revealed there was no padding on the wheelchair leg rests. Social Worker Designee #128 verified the old wheelchair did not have any padding on the leg rests to prevent Resident #34 from receiving new skin tears. Interview on 06/11/25 at 3:09 P.M. with Director of Nursing (DON) verified on 12/10/24 Resident #34 received a skin tear and the intervention that was to be put in place, to pad the leg rests on her wheelchair was not put in place. The DON verified due to the intervention not being put in place Resident #34 received multiple skin tears from her wheelchair. This deficiency represents non-compliance investigated under Complaint Number OH00165582.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined the facility failed to treat Urinary Tract Infections (UTI) in a timely manner for all residents. This affected one resident (#34) of one resident (Resident #34) for UTI. Findings Include: Review of the medical record for Resident #34 revealed an admission date 08/07/24. Diagnoses included diabetes mellitus, respiratory failure with hypoxia, chronic kidney disease, heart failure, dysphagia, and other feeding difficulties. Resident #34 had intact cognition. Review of the quarterly Minimum data Set (MDS) assessment dated [DATE] revealed Resident #34 had intact cognition. Resident #34 was dependent on transfers and had frequent incontinence of bowel and bladder. Review of the progress note dated 06/04/25 at 8:00 A.M. revealed the Nurse Practitioner (NP) #300 saw Resident #34. Resident #34 reported worsening burning and discomfort on urination and increase pain with urination. Resident #34 had followed with Infectious Disease (ID) in the past for her frequent, recurrent UTI's. NP #300 ordered a urine analysis (UA). On 06/05/25 the urine was collected via straight catheter and sent to hospital lab. The lab stated they were unable to accept the urine sample because it was not in the right container. The sample was brought back to the facility. On 06/06/25 Resident #34's urine sample was sent to another lab for analysis. On 06/09/25 received the urine culture sensitivity for lab. Interview on 06/10/25 at 10:56 A.M. with Resident #34's daughter revealed Resident #34 had a UTI and had not yet been treated. Resident #34's daughter stated it was over a week since Resident #34 started with symptoms. Interview on 06/11/25 at 8:50 A.M. with Resident #34 revealed she was having discomfort from her UTI but she had not started on an antibiotic yet and it had been a week. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/25 at 3:09 P.M. with the Director of Nursing (DON) stated Resident #34 was complaining last week about burning and frequent urination. The DON stated Resident #34 does have frequent UTI's, but this had been going on for some time and that was why we sent her to the Infectious Disease doctor. The NP #300 did order a urine analysis. A urine sample was collected on 06/05/25 via straight catheter for urine culture. The Urine was sent out to the hospital lab because it would be faster, but the hospital lab refused the sample because it was in the wrong container. The sample was brought back to the facility and the next day the other lab was to pick it up in the morning and they did not, so she called in a stat pick up and it was picked up on 06/06/25. The facility received the results on 06/09/25 at 5:24 P.M. The DON stated on 06/10/25 the NP #300 looked at the results and the results were sent over to the ID office. The DON stated they are waiting to hear back from the ID office. She called them on 06/11/25 and was told the doctor has not reviewed the lab results yet. The DON verified that it had been a long wait to get Resident #34 started on an antibiotic if it was needed. The DON stated Resident #34 had not been in pain from the UTI. The DON stated her expectation was that it should only take two days to get lab results. Review of the lab results dated 06/09/25 at 5:24 P.M. revealed clean catch urine was collected on 06/06/25 at 4:47 P.M. and received on 06/07/25 at 2:33 P.M. lab results were faxed to facility on 06/09/25 at 5:26 P.M. A handwritten note on the lab results indicated the lab results had been sent to ID office on 06/10/25. This deficiency represents non-compliance investigated under Complaint Number OH00165582.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility assessment, review of concerns logs, review of time sheets, review of facility policy, observation, and interviews the facility failed to ensure adequate nursing staff to ensure residents received medication timely and failed to provide adequate supervision. This affected five residents (#20, #23, #26, #32, and #51) of six residents reviewed for medication administration and one resident (#66) of two residents reviewed on the secure unit with the potential to affect all 72 residents residing in the facility. Findings included: 1. Medical record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including anxiety, depression, bipolar, and schizoaffective disorder. Review of resident concern form dated 06/05/25 revealed Resident #20 had concerns regarding medications. The resident reported he never got his night medication on 06/03/25 and night shift staff were not good with nurses and medications. Review of Resident #20's medication administration record (MAR) dated 06/2025 revealed the resident was ordered Risperidone 1 milligram (mg) at bedtime 8:00 P.M., for schizoaffective disorder, Hydroxyzine 50 mg at bedtime 9:00 P.M., for anxiety, and skin prep to bilateral heels every shift. Agency Licensed Practical Nurse (LPN) #300 had signed off the two medications and treatment were administered on 06/03/25. Review of Resident #20's medication administration audit from dated 06/09/25 revealed on 06/03/25 the resident's Risperidone 1 milligrams (mg) at bedtime for schizoaffective disorder and Hydroxyzine 50 mg at bedtime for anxiety was not administered 06/04/25 at 1:33 A.M. by Agency Licensed Practical Nurse (LPN) #300. Further review revealed LPN signed off she administered skin prep to bilateral heels that were due on 06/03/25 at 8:00 P.M. at 3:58 A.M., on 06/04/25. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 06/05/25 at 2:36 P.M., with Resident #20 revealed the facility was having a hard time getting staff, and night shift was the biggest problem. On night shift he doesn't get his medications as ordered. The resident reported he usually gets his medication crushed due to an esophageal issue (had surgery years ago); however, he doesn't trust night shift because there have been too many times he didn't get the correct medication that he asked them to take them whole. The resident reported he might not know all the names of medication, but he knows how many and what color his medications are. The resident reported the night before last (06/03/25) he never got his night medication at all. Around 9:30 P.M., he rang his light and staff member answered his light that he didn't know, and he asked if he could have his medication. The staff member told him she would tell the nurse. There was an agency nurse working that night. The resident reported he waited till midnight, and the nurse never showed up with his medication, so he went to bed. The next day Resident #26 was sitting in the hallway physically upset (crying) and he went to speak to her. Resident #26 told him she was upset because she didn't get her medication till 2:00 in the morning. Resident #20 went to find staff to help her but the nurse on the hall didn't seem to care so he went to 100 hall to get the nurse. He went back and sat with the resident until the nurse on 100 hall came over to help her. The resident confirmed he had reported the incident to the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #146. Interview on 06/05/25 at 3:00 P.M., with the Administrator revealed she was just notified by Resident #20 about not receiving medication on 06/03/25. The Administrator confirmed the resident was a reliable source and the nurse working that evening was an Agency nurse and she would have to look into the issue. Interview on 06/09/25 at 9:10 A.M., with DON and ADON revealed they had spoken to the LPN #300, and she reported if she signed the medication off then she administered them. The DON confirmed the medications were not administered timely because they were ordered on 06/03/25 at 8:00 P.M. and 9:00 P.M. , and the Agency LPN #300 did not administer the medication until 06/04/25 at 1:33 A.M. Interview on 06/09/25 at 9:54 A.M., with the Administrator revealed the medication on 06/03/25 may have been related to the agency nurse may have not been familiar with the residents, however medication administered at 1:00 P.M., was not acceptable. 2. Medical record review revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including pulmonary fibrosis, chronic obstructive pulmonary disease, diabetes, asthma, heart failure, hyperlipidemia, depression, anxiety, restless leg syndrome, epilepsy, obstructive sleep apnea, falls, and history of transient ischemic attack. Review of Resident #23's orders and MAR dated 06/2025 revealed the resident was ordered Metformin 750 mg twice (6:00 A.M. and 7:00 P.M.) daily for diabetes, Ropinirole 1 mg at bedtime (7:00 P.M.) for restless leg, Lubiprostone 24 milliequivalent (mcg) two times daily (6:00 A.M. and 7:00 P.M.) for constipation, Isosorbide 5 mg three times (6:00 A.M., 11:00 A.M., and 7:00 P.M.) daily for chest pain, Metoprolol 12.5 mg twice daily (6:00 A.M. and 7:00 P.M.) for hypertension, check blood sugar two times a day (6:00 A.M. and 7:00 P.M.) for diabetes, Ventolin inhalation two puffs three times (6:00 A.M., 11:00 A.M., and 7:00 P.M.) a day for shortness of breath and wheezing, Nortriptyline 30 mg at bedtime for depression (7:00 P.M.), Acetaminophen four times a day (7:00 A.M.,. 11:00 A.M., 4:00 P.M., and 7:00 P.M.) for pain and to remove thrombo-embolic hose at bedtime. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #23's Medication Administration Audit report dated 06/09/25 revealed on 06/03/25 the resident's 7:00 P.M. medications Metformin, Ropinirole, Lubiprostone, Isosorbide, Metoprolol, Ventolin, Nortriptyline, Acetaminophen were not administered until 06/04/25 from 1:36 A.M. to 1:53 A.M. The resident's blood sugar was not checked until 06/03/25 at 1:53 A.M., and her TED hose was not removed until 3:45 A.M. Review of Resident #23's resident concern form dated 06/05/25 revealed the resident doesn't receive evening medications until 11:00 P.M., and she would like them at 9:00 P.M. and she doesn't always get her patch on her back as she is supposed to. The DON explained to the resident that the medications were scheduled at open times from 7:00 P.M. to 11:00 P.M. and she will let staff know her preference was 9:00 P. M. and the nursing documentation shows she gets a new dressing daily. Interview on 06/09/25 at 11:00 A.M., with the DON confirmed Resident #23's medication on 06/03/25 was not administered timely. Interview on 06/10/25 at 7:04 A.M., with Resident #23 revealed her only concerns with the facility were staffing. The resident confirmed she doesn't get her medication timely. 3. Medical record review revealed Resident #26 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, emphysema, inadequate sleep hygiene, anxiety, and altered mental status. Review of Resident #26's orders dated 06/2025 revealed to administer Melatonin 3 mg at bedtime (7:00 P.M. to 11:00 P.M.) for insomnia. Review of Resident #26's Medication Administration Audit report dated 06/09/25 for 06/03/25 revealed Resident #26 didn't receive Melatonin until 06/04/25 at 2:07 A.M. Interview on 06/09/25 at 10:20 A.M., with the DON confirmed Resident #26 did not receive her Melatonin timely. 4. Medical record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including diabetes, depression, anxiety, and leg and hip pain. Review of Resident #51's orders dated 06/02/25 revealed to administer Trazodone 50 mg at bedtime (8:00 P. M.) for depression and Gabapentin 400 mg at bedtime (8:00 P.M.) for pain and anxiety. Review of Resident #51's medication administration audit dated 06/09/25 revealed on 06/03/25 Resident #51 did not receive her 8:00 P.M., Trazodone and Gabapentin until 10:58 P.M. Interview on 06/09/25 at 12:00 P.M., with the DON confirmed Resident #51 did not receive her 8:00 P.M., medication timely. 5. Medical record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including insomnia and anxiety. Review of Resident #32's MAR and orders dated 06/2025 revealed Alprazolam 0.25 mg at bedtime (8:00 P. M.) for anxiety and Trazodone 75 mg at bedtime (8:00 P.M.) for insomnia. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #32's concern form dated 06/05/25 revealed the resident reported she didn't get her medication on 06/03/25 until 2:30 A.M. on 06/04/25. The nurse told her she had 57 residents to give medication to. The resident reported she doesn't always get her medication in the evening. She was lucky if she got her blood pressure checked once, and it was supposed to be twice daily. She doesn't see housekeeping often in room. The solution was to change medication to open medication pass times, give agency staff resident preferences. There was an additional note that the nursing documentation showed the resident had gotten blood pressure checks twice daily and medication was administered as ordered. Review of Resident #32's Medication Administration Audit Report dated 06/09/25 revealed on 06/03/25 Resident #32's Alprazolam and Trazadone 8:00 P.M., medication was not administered until 06/04/25 at 2:27 A.M. Interview on 06/09/25 at 11:00 A.M., with the DON confirmed the resident's medication was not administered timely. Interview on 06/10/25 at 7:10 A.M., with Resident #32 revealed there were not enough nursing staff to administer medication timely. Medications were usually late but twice now she did not get medication until 2-3:00 A.M. There have been times she hasn't received her Parkinson medication and had to remind the staff. The resident reported she had two skin alterations, and the staff just gave her the ointment and Band-Aid to apply herself, but she can't' get the Band-Aid tight enough and the blood runs down her leg into her new shoes. 6. Review of Resident #66's medical record revealed Resident #66 was admitted to the facility on [DATE] with diagnoses including heart failure, dementia, diabetes, kidney disease, dementia, and depression. The resident resided on the secure unit, however, was a previous resident of the attached Assisted Living (AL). Review of Resident #66's progress note dated 05/24/25 at 5:30 P.M., revealed the nurse was alerted by staff that the resident was pacing the hallways looking for exit and was not able to be redirected. Provider notified and orders given for Hydroxyzine 25 milligrams every 12 hours as needed. Review of Resident #66 progress note dated 05/24/25 at 6:19 P.M., revealed Hydroxyzine was ineffective. Review of Resident #66's change in condition progress note dated 6:40 P.M., revealed notified granddaughter that the resident had exited the secured unit. The granddaughter was curious how she had gotten out and glad she was okay. Interview on 06/06/25 at 11:39 A.M., with Resident #66's granddaughter revealed she doesn't think there was enough staff on the secure unit to supervise all the residents due to most of the residents having behavioral issues. The granddaughter reported Resident #66 had eloped from the secured unit and was found on the other side of facility which was a pretty good distance from the secure unit on 05/24/25. (continued on next page)

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	366051	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Northpointe	3291 Northpointe Drive Zanesville, OH 43701

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Review of an anonymous complaint dated 05/12/25 revealed there was only one nurse for the entire facility 04/12/25 and 04/19/25. There was only one aide for two large hallways, staff combining break times resulting in staff being off the floor for over an hour, not enough staff to assist residents in and out of bed or provide routine wellness checks. Review of the schedule and time sheets dated 04/12/25 revealed on night shift (6:00 P.M. to 7:00 A.M.) the licensed nurse in the building was the Director of Nursing (DON). The DON was responsible for 300 hall, the secure unit and assisted living. There was a medication tech (MT) that was responsible for 100/200 hall as well. Further review of the schedule and time sheets dated 04/19/25 revealed there was only one licensed nurse from 2:45 A.M. to 6:05 A.M. and one medication tech on 04/19/25. Review of the census dated 04/12/25 revealed there were 72 resident in the skilled nursing facility and 17 residents in the assisted living (AL) for the total of 89 residents. Review of the census dated 04/19/25 revealed there were 74 residents in the skilled nursing facility and 17 residents in the AL for the total of 91 residents. Interview on 06/11/25 at 12:30 P.M., with the Staffing Coordinator #111 confirmed on 04/12/25 for the night shift there was one licensed nurse for 89 residents and 04/19/25 from 2:45 A.M. to 6:05 A.M., there was only one licensed nurse for 91 residents. The Staffing Coordinator confirmed the facility shares staff with the attached AL. 8. Observation on 06/04/25 at 7:20 A.M., of the three medication carts on 200 hall revealed the cart for rooms 216-223 had seven medication cups filled with medications. The medication cups had a first name and room number. Two of the cups had the same first name, however the room number was different. At the time of the observation, interview with LPN #179 confirmed she pre-sets up the resident medication to make the administration go faster because she must oversee the medication technician, perform assessments, and treatments. 9. Review of the facility assessment dated [DATE] revealed the total licensed skilled beds was 75. There were 12 beds in memory care, 11 beds in rehab, and 64 beds in the long-term care. The average daily census was 56. Based on the resident population and their need for care and support there should be six licensed nurses providing direct care and 14 CNA's. The campus leadership utilizes multiple resources to determine staffing needs and ensure resident needs are being met. Some areas included but not exclusive include resident needs, number of residents assigned to each staff member, medication administration for compliance, pattern of resident care needs (bathing, toileting, call light response time, etc.), monitoring staff appearing to be rushed, and monitoring employee turnover. Review of the concern log dated 03/05/25 to 05/29/25 revealed 22 concerns with grooming, staffing, call lights, not receiving assistance out of bed, oral hygiene, showers, and toileting. The facility assessment didn't include the attached Assisting Living. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 06/05/25 at 11:40 A.M., with the Administrator revealed the staffing ration was based on residents' needs and census. Currently the facility has one full-time night shift positions open and one part-time nurse shift. The facility had two additional night shifts open, but they just filled those positions, and the new staff will start training. The facility currently had no open CNA openings. There were four CNA's that will take the LPN boards soon as well. The facility was currently using Agency staffing. The Administrator felt staffing had been a concern due to new ownership in December 2024, however, feels the residents needs were being met. Interview on 06/05/25 from 7:00 A.M. to 3:00 P.M., with Anonymous Staff #303 revealed facility was having staffing issues especially on night shift. Resident have voiced concerns regarding not receiving pain mediation timely, residents' hygiene had been poor including oral hygiene. Treatments have not been completed per orders. Medication was administered late. Dietary had been helping deliver meal trays and not ensuring the tray was in reach or set up. Pressure and fall interventions were not in place per plan of care. Staff were not staying due to the working conditions. Interview on 06/10/25 at 7:17 A.M., with Resident #41 revealed she was told the facility was the best in the area but there had been changes in ownership and the place had gone downhill especially the night shift staffing. The facility was using travel nurses, and they don't know the residents. You never know when you will get your medications. On nights you have to wait 30 minutes or longer for staff to answer your call light. You never see the doctor because she comes between 4:00 A.M.-5:00 A.M. The resident reported her blood pressure had not been properly managed, and she had been having headaches. Staff were aware of her concerns, and she reached out to social service last week to make a request in for a transfer to another facility. Interview on 06/10/25 from 7:00 A.M. to 4:00 P.M., with anonymous Staff Member #400 revealed it was challenging to answer call lights when there was only one nurse and one aide for two hallways. The staff member reported she heard a lot of complaints from residents regarding not getting medication or not getting medication timely. Dietary staff try to help but they don't place meal trays in reach. She doesn't know if the staffing issue was related to the new staff or agency staff can't handle the workload. Interview on 06/10/25 at 10:05 A.M. with the Staffing Coordinator #111 revealed her staffing goal was 3.2 PPD per day. That number included the skilled nursing facility and AL. On day shift she would like to see five nurses and eight CNA and two nurses and six CNAs on nightshift. On night shift there had been several occasions when there will only be one nurse and one medication tech. The facility had been using agency nursing on night shift as well. The Staffing Coordinator reported she could not really answer if one nurse was adequate on night shift for 72-74 residents in the skilled and 13-17 resident in the AL. She wasn't clinical so she was not aware there was concerns with staffing not administering medication timely. Interview on 06/10/25 at 11:28 A.M. with anonymous Family Member #401 revealed staff were coming and going. The current staff were overworked and short-handed. Staff were transferring her mother by themselves due to there was no staff to assist. Her mom required two staff for transfers. Her mom had laid in urine and bowel movement for hours. It was difficult to find staff for help. Call lights were going off, residents were not getting medications as ordered, showers and oral care was not being performed adequately. Residents were declining due to the poor care. This deficiency represents non-compliance investigated under Complaint Number OH00165582.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of Medscape, observation, interview, and policy review the facility failed to ensure the facility medication error rate was not greater than five percent. The facility had five medication errors out of 28 opportunities resulting in a medication error rate of 17.8%. This affected two residents (#20 and #49) of three residents observed for medication administration. Findings included: 1. Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including bipolar, anxiety, schizoaffective disorder, depression, obsessive-compulsive disorder, cirrhosis of the liver, type two diabetes, hypertension, non-ST elevation myocardial infarction, hyperlipidemia, edema, atrial fibrillation, and the need for assistance with personal care. Review of Resident #20's current orders dated 06/01/25 revealed Metoprolol Succinate extended release (ER) 25 milligrams (mg) give one tablet by mouth daily for hypertension, Sertraline 150 mg daily for bipolar, and Spironolactone 50 mg daily for ascites. May crush medications unless contraindicated. Observation of Resident #20's medication administration pass with Medication Technician (MT) #107 on 06/04/25 at 7:35 A.M., revealed the MT crushed the resident's Metoprolol Succinate ER and omitted the Sertraline and Spironolactone. The MT confirmed during observation there were 12 pills (Multivitamin with minerals, Lactobacillus capsule, Ferrous Sulfate, Plavix, Lasix, glipizide, Hydroxyzine, Memantine, Metoprolol, Ondansetron, Xifaxan, and Xarelto) in the medication cup. Review of Resident #20's medication administration record (MAR) after the medication administration observation revealed the resident should have received 14 pills. MT #107 had signed off she administered Sertraline and Spironolactone. Review of Medscape revealed Metoprolol Succinate should not be crushed or chewed. Review of Nurse Practitioner (NP) note dated 06/04/25 revealed staff reported the resident had been receiving his Metoprolol ER crushed. There were no adverse events noted from receiving Metoprolol Succinate ER crushed. Order included to discontinue and start Metoprolol tartrate 12.5 mg twice daily with blood pressure and pulse. Interview on 06/04/25 at 9:46 A.M. and 10:14 A.M., with MT #107 and Assistant Director of Nursing (ADON) #146 confirmed Metoprolol ER should have not been crushed. MT #107 reported she was not aware the Metoprolol could not be crushed. The ADON reported staff always crush the resident's medication per his request. MT #107 confirmed she had not administered any additional medication to Resident #20 since the observation at 7:35 A.M. The MT confirmed she had administrated 12 pills during the observation with the surveyor. However, after reviewing the MAR with the surveyor the resident should have received 14 pills. The MT confirmed she had signed off the Sertraline 150 mg and Spironolactone 50 mg, however she did not administer those medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/25 at 2:36 P.M., with Resident #20 revealed it was not uncommon to receive the wrong medication especially on night shift. The resident reported he doesn't know the name of all his medications; however, he knows how many pills he receives and the colors. The resident reported he likes his medication crushed because he had esophageal surgery years ago and has a difficult time swallowing the pills. On night shift he doesn't like the staff to crush the pills because he doesn't trust them to give the correct medications due to past experiences. 2. Medical record review revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including cerebral infarction due to thrombosis of right posterior cerebral artery, acute respiratory failure, type two diabetes, atelectasis, chronic heart failure, hypertension, dysphagia, peripheral vascular disease, gastro-esophageal reflux disease, and urinary tract infection (UTI). Review of Resident #49's current orders dated 06/01/25 revealed Amlodipine 5 mg give two tablets by mouth once daily for hypertension and Metoprolol 100 mg one tablet twice daily for hypertension. Observation on 06/04/25 at 7:29 A.M., of Resident #49's medication administration with Licensed Practical Nurse (LPN) #179 revealed she had only administered one Amlodipine 5 mg tablet and omitted the Metoprolol. The LPN reported the Metoprolol had been unavailable since 05/24/25. Review of NP note dated 06/04/25 revealed the resident was seen today due to nursing reported the resident had potentially been out of Metoprolol since 05/24/25. The resident receives Amlodipine, Metoprolol, and Valsartan for hypertension. There was no harm noted from omitted medication. Added blood pressure monitoring and to report uncontrolled blood pressures. The blood pressure goal was less than 140/90 mm/Hg. Interview on 06/04/25 at 7:29 A.M. and 9:29 A.M., with LPN #179 confirmed she only administered one Amlodipine 5 mg, and the order was for two tablets. The LPN confirmed she had called the pharmacy on 05/24/25 to re-order the Metoprolol however it had still not arrived, and she called again yesterday 06/03/25 and it was supposed to be on the delivery truck last night but did not arrive. The LPN reported she could not pull the medication for the contingency box due to there was only two 25 mg of Metoprolol and the resident needed 100 mg. Interview on 06/04/25 at 2:55 P.M., with the Director of Nursing (DON) revealed the facility had the NP come today (06/04/25) and see Resident #20 and #49 due to the observed medication errors with the resident's Metoprolol. Review of the facility's policy titled Administering Medication undated revealed medication shall be administered in a safe and timely manner, as prescribed. The individual administering the medication must initial the resident's MAR on after giving the medication. This deficiency represents non-compliance investigated under Complaint Number OH00165582.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, observation, and policy review the facility failed to ensure residents were free from significant medication errors. This affected one resident (#49) of three residents reviewed for medication administration and one resident (#34) of three residents reviewed for urinary tract infections (UTI). Findings included: 1. Medical record review revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including cerebral infarction due to thrombosis of right posterior cerebral artery, acute respiratory failure, type two diabetes, atelectasis, chronic heart failure, hypertension, dysphagia, peripheral vascular disease, gastro-esophageal reflux disease, and urinary tract infection (UTI). Review of Resident #49's orders dated 05/01/25 and 06/01/25 revealed Metoprolol 100 mg one tablet twice daily for hypertension. Review of Resident #49's Medication Administration Record dated 05/01/25 to 06/04/25 revealed the Metoprolol was not administered at 5:00 P.M., 05/05/25, 05/07/25, 05/10/25 , 05/12/25, 05/17/25, 05/22/25, 05/28/25, 06/03/25 and 6:00 A.M./9:00 A.M. on 05/18/25, 05/28/25, 06/03/25, and 06/04/25. Review of the pharmacy invoices dated 05/06/25 and 05/24/25 revealed on 05/07/25 and 05/24/25 60 Metoprolol 100 mg tablets were delivered. Observation on 06/04/25 at 7:29 A.M., of Resident #49's medication administration with Licensed Practical Nurse (LPN) #179 revealed she omitted the Metoprolol due to the Metoprolol had been unavailable since 05/24/25. Interview on 06/04/25 at 9:29 A.M. with LPN #179 confirmed she had signed of the Metoprolol was administered on 05/28/25, 06/03/25, and 06/04/25 when she did not administer the medication due to it was not available. The LPN reported she had re-ordered the Metoprolol on 05/24/25, however it had not arrived yet. Interview on 06/04/25 at 1:26 P.M. and 06/05/25 at 7:26 A.M., with the Assistant Director of Nursing (ADON) #146 revealed on 05/07/25 the pharmacy had delivered 60 Metoprolol 100 mg tablets and there should have lasted 30 days (06/05/25) if the Metoprolol was started on 05/07/25. Observation of medication cart with the ADON revealed no evidence the Metoprolol delivered on 05/07/25 was in the medication cart. The ADON confirmed there should have been 16 tablets left from the card that was delivered on 05/07/25 that were not accounted for. The ADON reported they had found the 60 tablets of Metoprolol that were delivered 05/24/25 in the medication room, however they were not used. The ADON reported she had interviewed two other staff that administered the Metoprolol after 05/24/25 and the staff confirmed Metoprolol 100 mg medication was in the cart to administer. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/25 at 7:26 A.M. and 8:15 A.M. with the Director of Nursing (DON) confirmed there was no documented evidence the Metoprolol was administered at 5:00 P.M., 05/05/25, 05/07/25, 05/10/25 , 05/12/25, 05/17/25, 05/22/25, and 6:00 A.M./9:00 A.M., dose on 05/18/25. The DON reported she spoke to the facility staff member that worked on some of those dates, and she could not recall if she administered the medication or not and the other dates were agency staff and there was no way to confirm if they had administered the medications. Interview on 06/05/25 at 7:42 A.M. and 7:49 A.M., with LPN #127 and LPN #134 revealed they had worked on 05/29/25 and administered Metoprolol 100 mg to Resident #49. Neither nurse could recall how many pills may have been left in the blister card, however reported they would have not signed off the medication was administered if they didn't administer it. Review of the facility's policy titled Administering Medication (undated) revealed medication shall be administered in a safe and timely manner, as prescribed. The individual administering the medication must initial the resident's MAR on after giving the medication. 2. Review of the medical record for Resident #34 revealed an admission date 08/07/24. Diagnoses included diabetes mellitus, respiratory failure with hypoxia, chronic kidney disease, heart failure, dysphagia, and other feeding difficulties. Resident #34 had intact cognition. Review of the quarterly Minimum data Set (MDS) dated [DATE] revealed Resident #34 had intact cognition. Review of the physician orders for April 2025 revealed on 04/04/25 Ertapenem Sodium (antibiotic) 1 gram, use 500 milligrams (mg) intravenously in the afternoon for Urinary Tract Infection (UTI) for 14 days. Review of the Medication Administration Record for April 2025 revealed Resident #34 did not receive her Ertapenem Sodium IV antibiotic on four days (04/07/25, 04/12/25, 04/13/25 and 04/15/25) out of the 14 days she was to receive the medication. Review of the infection tracking antibiotic surveillance log revealed on 04/04/25 Resident #34 was supposed to start the antibiotic and end on 04/17/25 (14 days). Interview on 06/11/25 at 3:09 P.M. with the Director of Nursing (DON) verified Resident #34 had frequent UTI's and was being seen by the infectious disease physician. The DON verified Resident #34 missed four doses of IV antibiotic out of 14 doses. This deficiency represents non-compliance investigated under Complaint Number OH00165582.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review the facility failed to ensure medication carts were properly secured and medication were properly stored and labeled. This had the potential to affect 11 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11) of 11 residents residing on 100 hall and 40 residents (#12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, and #51) of 40 residents residing on 200 hall. The facility census was 72. Findings included: 1. Observation of 100 hall on 06/04/25 at 6:59 A.M., revealed the 100-medication cart was left unlocked and unattended. The medication cart was located between rooms [ROOM NUMBERS]. Interview on 06/04/25 at 7:00 A.M., with Licensed Practical Nurse (LPN) #133 confirmed she had left the medication cart unlocked and unattended. The LPN reported she was on 300 hall getting report. Interview on 06/04/25 at 11:54 A.M., with the Director of Nursing (DON) confirmed medication carts should be locked when unsupervised. The facility had already initiated staff training. 2. Observation on 06/04/25 at 7:20 A.M., of the three medication carts on 200 hall revealed the cart for rooms 216-223 had seven medication cups filled with medications. The medication cups had a first name and room number. Two of the cups had the first same name, however the room number was different. At the time of the observation, LPN #179 confirmed she pre-sets up the medication to make the administration go faster because she must oversee the medication technician, perform assessments, and treatments. Further observation of the medication cart for rooms 201-209 revealed there were 14.5 loose tablets, not labeled or packaged, in the first drawer. At the time of the observation, findings were confirmed with Medication Technician (MT) #107. LPN #179 reported pharmacy was just at the facility last week and did not identify any concerns with the medication carts. The medication cart for rooms 210-215 contained 11 whole pills and 3.5 half loose tablets, not labeled or packaged, in the first and last drawer of the medication cart. At the time of the observation, findings confirmed with Assistant Director of Nursing (ADON) #146 during the observation. Interview on 06/04/25 at 11:54 A.M., with the Director of Nursing (DON) confirmed staff should not be pre-setting up medications. The DON reported she started staff education on ensuring medication carts were locked when unattended, carts must be free of loose of pills and debris, and staff cannot pre-pull medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Storage of Medication dated 09/01/21 revealed the facility should store all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they were received. The nursing staff shall be responsible for maintaining medication storage. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. Compartments including carts containing drugs and biologicals shall be locked when not in use and shall not be left unattended if open or otherwise potentially available to others. Each resident's medication shall be assigned to an individual cubical, drawer, or other holding area to prevent the possibility of mixing medications of several residents. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00165582.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to ensure all residents had required assistive device available during meal times. This affected one resident (#34) of one resident that was reviewed for assistive devices. Findings Include: Review of the medical record for Resident #34 revealed an admission date 08/07/24. Diagnoses included diabetes mellitus, respiratory failure with hypoxia, chronic kidney disease, heart failure, dysphagia, and other feeding difficulties. Resident #34 had intact cognition. Review of physician orders for June 2025 revealed regular diet, regular texture and thin consistency for liquids. Divided plate, Kennedy cup (cup with handles and lid) and built-up utensils for all meals as tolerated dated 11/26/24. Review of the plan of care for Resident #34 revealed the resident had an activity of daily living (ADL's) self-care performance deficit related to cognitive impairment, fluctuating ADL's, generalized weakness and poor coordination. Interventions included provide needed adaptive equipment: divided plate, Kennedy cup and built-up utensils for all meals as tolerated. Interview on 06/11/25 at 8:50 A.M. with Resident #34 revealed she needs to have her clear cup that says [NAME] on it and likes to have her built-up utensils with meals to help her get food and drink in her mouth without making a mess. Observation at that time revealed Resident #34's breakfast tray was in front of her. There was no Kennedy cup or built-up utensils on her tray. Resident #34's tray had regular utensils and Styrofoam cups with lid and straw. Resident #34 stated it was much easier to use the Kennedy cup and built-up utensils and more comfortable to use. Observation of the meal ticket on Resident #34's meal tray revealed adapted equipment: divided plate, Kennedy cup with lid, built-up utensils for all meals. Interview on 06/11/25 at 9:06 A.M. with Licensed Practical Nurse (LPN) #179 verified that Resident #34 was indeed to have a Kennedy cup and built-up utensils for all meals and that the breakfast tray did not have a Kennedy cup or built-up utensils. Review of the facility policy Assistance with Meals, dated 09/2021 revealed residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards and/or specialized cups. This deficiency represents non-compliance investigated under Complaint Number OH00165582.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366051	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Northpointe	3291 Northpointe Drive Zanesville, OH 43701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and policy review the facility failed to ensure medication administration was accurately documented on the medication administration record (MAR). This affected one resident (#49) of three residents reviewed for medication administration. Findings included: 1. Medical record review revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, chronic right heart failure, hypertension, peripheral vascular disease, and the need for assistance with personal care. Review of Resident #49's current orders revealed on 04/03/25 the resident was ordered Metoprolol 100 milligrams (mg) twice daily for hypertension. Observation on 06/04/25 at 7:29 A.M., of Resident #49's medication administration revealed no evidence Metoprolol was available to administer. Licensed Practical Nurse (LPN) #179 reported the Metoprolol 100 mg had been unavailable since 05/24/25. The LPN stated she called the pharmacy on 05/24/25 to re-order the Metoprolol and pharmacy reported they did not have an order for Metoprolol. The LPN reported she had to discontinue the order and re-write the order so it would appear for pharmacy so they could re-fill. Yesterday she called pharmacy again due to the medication had not arrived. LPN #179 confirmed she had not administered the Metoprolol last week when she worked or this week. The LPN confirmed she could not pull from the contingency box due to there being two 25 mg tablets and the resident needed 100 mg. The LPN reported she was going to reach out to pharmacy again today. Review of Resident #49's medication administration records dated 05/2025 and 06/2025 revealed LPN #179 had signed off she had administered the Metoprolol 100 mg on 05/28/25 and 06/03/35 at 6:00 A.M. and 4:00 P.M., and today 06/04/25 at 6:00 A.M. Review of Resident #49's progress notes dated 05/2025 to 06/2025 revealed no evidence the Metoprolol was not administered or unavailable. Interview on 06/04/25 at 9:29 A.M., with LPN #179 confirmed on 05/28/25, 06/03/25, and 06/04/25 she had signed off she had administered the Metoprolol when she didn't administer the medication. The LPN reported she would go back and correct the documentation to reflect the medication was not administered on those dates. Review of the facility's policy titled Administering Medication (undated) revealed if a drug was withheld, refused, or given at times other than the scheduled time, the individual administering the medication shall use the appropriate code when documenting. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00165582.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366051	A. Building B. Wing	06/16/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on review of the Payroll Base Journal (PBJ) Staffing Data Report and interview the facility failed to submit staffing information to Centers for Medicare and Medicaid Services (CMS) timely. This had the potential to affect all 72 residents residing in the facility. Findings included: Review of the PBJ Staffing Data Report ran 05/29/25 revealed the facility failed to submit data for the first quarter (October 1st to December 31st) in 2025. The facility also triggered for a one-star staff rating. Interview on 06/05/25 at 9:08 A.M. and 9:50 A.M., with the Chief of Operation (CEO) confirmed there was no documented evidence the first quarter staffing data was reported to CMS. The CEO reported that the facility changed ownership in December of 2024, and it was the previous ownership responsibility to report the staff data to CMS. The CEO reported on April 1st of 2025 he had received an e-mail that the previous owner sent the data to a contracted company on 02/11/25. The contracted company was responsible for reporting the data to CMS, however there was no documented evidence that the contracted company had sent the data to CMS. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00165582.

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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 medical record review, observation, interview, and policy review the facility failed to ensure enhanced barrier precaution (EBP) were maintained during resident care and failed to ensure infection control practices were maintained during medication administration. This affected one resident (#4) of 72 residents observed during the tour and one resident (#49) of three residents observed for medication administration. Findings included: 1. Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including calculus of gallbladder with acute cholecystitis with obstruction, acute renal failure, diabetes, need for assistance with personal care, urine retention, and stress incontinence. Review of Resident #4's orders dated 06/04/25 revealed the resident had a cholecystostomy tube and was on enhanced barrier precautions (EBP). Review of Resident #4's impaired gastrointestinal status related to status post gallbladder stone cholestostomy plan of care dated 05/23/25 and revised 06/09/25 revealed on 06/04/25 EBP related to cholestostomy drain in place was initiated. Observation on 06/04/25 at 6:59 A.M. revealed Certified Nursing Assistant (CNA) #144 and #163 were transferring Resident #4 out of the bed via a Hoyer lift without PPE on. The resident had an enhanced barrier sign on door and a protective personal (PPE) equipment cart outside the room. The CNA's confirmed during observation they should be wearing gloves and gowns when providing direct care to Resident #4 because she was on EBP. Interview on 06/04/25 at 11:54 A.M., with the Director of Nursing (DON) confirmed the CNAs should have been wearing PPE when transferring Resident #4 with a Hoyer lift due to the resident being on EBP. Interview on 06/09/25 at 10:30 A.M., with the DON revealed the nurse had updated the diagnosis on the order and care plan for the EBP on 06/04/25 due to the order had included urinary catheter. The resident was admitted with a urinary catheter but the catheter had been discontinued. Review of the facility's policy titled EBP (dated 01/2024) revealed EBP is an infection control method used in facilities to reduce transmission of drug-resistant organisms. EBP refers to the use of gown and gloves during high-contact (transferring, providing hygiene, dressing, bathing, etc.) activities for a resident with chronic wounds, indwelling devices, or known infection or colonization with a resistant organism. 2. Medical record review revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, chronic right heart failure, hypertension, peripheral vascular disease, and the need for assistance with personal care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of medication administration on 06/04/25 at 7:29 A.M. revealed Licensed Practical Nurse (LPN) #179 failed to perform hand hygiene prior to medication administration. The LPN removed Resident #49's Losartan Potassium 100 milligrams (mg) from the blister pack directly into her hands then she placed the medication in the cup. The surveyor confirmed observation with LPN #179 however LPN #179 never replaced the medication and continued with medication administration. The LPN then removed one Aspirin 81 mg and one Calcium from stock bottles and placed the pills directly into the palm of her hand and then into the medication cup. The LPN administered the medication to the resident. Confirmed observation with LPN #179 at the time of observation. The LPN reported she was a new nurse. Interview on 06/04/25 at 11:54 A.M., with the DON confirmed LPN#179 should never place pills directly in her hands and should have placed the medication directly into the medication cup or on the lid then into the medication cup. Review of the facility's policy titled Administering Medications (undated) revealed staff shall follow established facility infection control procedures (handwashing, antiseptic technique, gloves, isolation precaution, etc.) for the administration of medications, as applicable. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00165582.