

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Oaks at Northpointe		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure Resident #35's family was notified of missing hearing aids in a timely manner. This affected one (Resident #35) out of three residents reviewed for notification of change. The facility census was 73. Findings include:A review of Resident #35's medical record revealed admission date 05/01/18 with diagnoses including but not limited to hearing loss, degenerative disease of the nervous system, seizures, and assistance with personal cares. A review of Resident #35's physician orders revealed an order dated 11/30/24 to check bilateral hearing aid batteries and tubes every shift and as needed (PRN), two times per day, and an order dated 05/20/25 for bilateral hearing aids to be placed in a storage case in the medication cart each night at bedtime.A review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #35 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of three out of possible 15, had moderate difficulty in hearing, wore hearing aids, and used a custom wheelchair for mobility.A review of Resident #35's October 2025 Medication Administration Record (MAR) revealed the order for bilateral hearing aids to be placed in a storage case in the medication cart each night at bedtime was marked as being completed from 10/01/25 to 10/15/25. From 10/16/25 to 10/31/25, the order was marked as not being completed. Further review of Resident #35's November 2025 MAR dated 11/01/25 to 11/30/25 revealed the order for bilateral hearing aids to be placed in a storage case the in medication cart each night at bedtime was marked as not being completed.A review of Resident #35's progress notes dated 10/16/25 to 11/10/25 revealed there were no notes referencing the bilateral missing hearing aids for Resident #35 and no notes reflecting Resident #35's family was notified of the missing hearing aids. Further review revealed two progress notes dated 11/10/25 related to Resident #35 being assessed by audiology at the facility, and the audiologist will be sending Resident #35's new bilateral hearing aids to the facility.A review of the facility's Resident Concern Form dated 10/29/25 at 6:00 P.M. revealed Resident #35's family member reported several concerns including missing bilateral hearing aids. Resolution of the concerns for the missing hearing aids was to request Resident #35 to be seen by the audiologist for an assessment to replace the hearing aids. The Resident Concern Form was reviewed by the Grievance Officer on 10/31/25.An interview on 12/01/25 at 2:45 P.M. with the Administrator verified Resident #35's bilateral hearing aids were missing with no family notification when first reported to be missing on 10/17/25, and Resident #35's family member had reported the missing hearing aids to the facility on [DATE] via a Resident Concern Form. The Administrator stated the facility looked for the missing hearing aids on 10/17/25 and a group message was sent out to the facility staff asking for any information concerning the missing hearing aids, with the last known observation of the bilateral hearing aids on the night of 10/15/25 when they were removed and placed on the medication cart by Certified Nursing Assistant (CNA) #400.This deficiency represents non-compliance investigated under Complaint Number 2678084.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366051
		If continuation sheet Page 1 of 2

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to ensure the physician ordered diet was followed for Resident #35, who had a swallowing impairment. This affected one (Resident #35) out of three residents reviewed for diet orders. The facility census was 73. Findings include: A review of Resident #35's medical record revealed admission date 05/01/18 with diagnoses including but not limited to hearing loss, degenerative disease of the nervous system, seizures, and assistance with personal cares. A review of Resident #35's speech summary notes dated 01/09/24 to 02/19/24 revealed laryngeal/pharyngeal performances were impaired with a history of penetration of liquids when a straw was used. A review of Resident #35's physician orders revealed an order dated 11/25/24 for regular diet, regular texture, regular/thin consistency, cut up meats, no straws, finger foods as able, plate guard and gray built-up utensils, no spaghetti. A review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #35 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of three out of possible 15, had moderate difficulty in hearing, wore hearing aids, and used a custom wheelchair for mobility. An observation of Resident #35's room on 12/01/25 at 11:15 A.M. revealed a white Styrofoam cup with a lid and a straw on the windowsill near the recliner filled with fresh ice water dated 12/01/25. An observation of Resident #35's room on 12/01/25 at 12:30 P.M. revealed a white Styrofoam cup with a lid and a straw on the windowsill near the recliner filled with fresh ice water dated 12/01/25. Further observation revealed a sign located on the wall above Resident #35's bed stating no straws were to be used. An interview on 12/01/25 at 12:35 P.M. with Licensed Practical Nurse (LPN) #373 confirmed the white Styrofoam cup with a lid and a straw was filled with fresh ice water and dated 12/01/25. LPN #373 stated the staff all knew Resident #35 does not use straws for any drinks, and the family provides sip cups or travel type tumblers for Resident #35. An interview on 12/01/25 at 3:45 P.M. with the Administrator revealed the Business Office Manager (BOM) had been helping staff with providing the morning ice and water and had placed the lidded cup with a straw in Resident #35's room. The Administrator stated the BOM was unaware of Resident #35's restriction of no straws for drinking liquids. This deficiency represents non-compliance investigated under Complaint Number 2678084.</p>		