

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

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No. 0938-0391

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 07/29/2025
NAME OF PROVIDER OR SUPPLIER The Oaks Rehabilitation and Healthcare Center		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 0684 Level of Harm - 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, employee statement review, facility investigation review, hospital record review, employee file review, interviews and facility policy review the facility failed to timely and adequately assess and identify a major injury status post fall resulting in a delay in medical intervention. Actual harm occurred on 06/13/25 at approximately 9:30 P.M. when Resident #54, who was dependent on staff and the use of a mechanical lift for transfers, was discovered by Certified Nursing Assistant (CNA) #250 lying on the floor of her room, in front of her wheelchair. Resident #54 appeared to be in pain and was unable to recall what had occurred. CNA #250 and CNA #169 used a mechanical lift to place the resident in bed, without an assessment or direction from Licensed Practical Nurse #131. On 06/14/25 at 6:51 A.M. the resident complained of pain in her right leg with abnormal range of motion noted. The physician was notified, and an x-ray of the right hip and pelvis was ordered and completed at 7:47 A.M. However, no results were received until 2:00 P.M. when it was identified the resident's right femur was fractured. The resident was transferred to the hospital where she was admitted and subsequently had surgical repair of the right femur fracture. This affected one resident (Resident #54) of three residents reviewed for falls. The census was 65. Findings include: Review of Resident #54's medical record revealed initial admission date of 12/01/24 with diagnoses including multiple sclerosis (MS), pain, neuromuscular dysfunction of bladder and depression. Review of Resident #54's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #54 had impaired cognition and was dependent on staff for transfers with a mechanical lift and used a motorized wheelchair for mobility. Review of Resident #54's care plans revealed an at risk for falls care plan related to functional problems, general weakness dated 01/21/25 with interventions including but not limited to educate the resident and family to call for assistance before transferring, (keep) personal items within reach, and wear non-skid footwear. Further review revealed an Activities of Daily Living care plan dated 05/18/25 that indicated using a mechanical lift for transfers. Review of the medical record revealed no progress note documentation of an incident involving the resident or an assessment, including vital signs, on 06/13/25. There was no fall risk evaluation/assessment located in the resident's medical record prior to 06/14/25. Further review of the medical record revealed a fall occurrence evaluation document dated 06/14/25 at 6:37 A.M. and authored by LPN #131. The document included Resident #54 was not in pain and there were no injuries observed or documented. Review of Resident #54's progress note dated 06/14/25 at 6:51 A.M. and authored by LPN #131 revealed a fall occurrence note where Resident #54 described a fall as I leaned too far forward in my wheelchair. LPN #131 entered the date and time of the incident as 06/14/25 at 6:52 A.M. LPN #131 documented no external injuries, but the patient was experiencing pain in the right hip. The pain was worse with movement. The on-call physician and Director of Health Services (DHS) were notified of the incident. Review of Resident #54's June 2025 Medication Administration Record (MAR) revealed on 06/14/25 at 10:30 A.M. two Extra Strength Tylenol 500 mg were administered to Resident #54 by LPN #255 for pain rated a seven out of 10 on the pain scale (1-10 pain rating scale with 0 being no pain and 10 being the worst pain) to right the leg. Further review of Resident #54's progress note dated 06/14/25 at 10:34 A.M. revealed Resident #54 received (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	two tablets of Extra Strength Tylenol 500 milligrams (mg) for pain. Review of Resident #54's progress note dated 06/14/25 at 2:00 P.M. revealed x-ray results indicated a fractured right femur. LPN #255 notified the on-call physician for further instructions and received an order to send Resident #54 to the emergency department for further evaluation and treatment. Review of Resident #54's x-ray results with an examination date of 06/14/25 at 7:47 A.M. with a reporting date of 06/14/25 at 2:00 P.M. revealed the resident had a comminuted fracture of the midshaft of the right femur. Review of Resident #54's progress notes dated 06/14/25 at 2:15 P.M. revealed emergency medical services (EMS) ambulance arrived at the facility. Resident #54 was transferred to the stretcher and exited the facility with EMS crew. A report was called to the hospital ED and emergency contacts were notified. Review of Resident #54's hospital record dated 06/15/25 at 6:83 P.M. revealed Resident #54 received surgery to repair the right femur fracture. Resident #54 returned to the facility on [DATE]. Review of CNA #250's statement dated 06/14/25 and interviewed by the previous DHS #172 revealed an incident (fall) date was 06/13/25. CNA #250 stated he heard yelling as rounds were being completed. CNA #250 entered Resident #54's room and observed the resident on the floor in front of the wheelchair back by the bathroom at approximately 9:00 P.M. - 9:30 P.M. CNA #250 went to get another staff member to assist with the use of the mechanical lift to get the resident off the floor. The nurse was present when CNA #169 was asked to help with transferring Resident #54. CNA #250 did not directly address LPN #131 when asking for assistance. CNA #250 stated he did not follow up with LPN #131 when she did not assess Resident #54 prior to moving the resident to bed. CNA #250 stated he was too concerned with getting Resident #54 up off the floor. The statement included Resident #54 did not complain of pain during the transfer from the floor to the bed. CNA #250's statement was signed by the Administrator and the DHS on 06/14/25, but CNA #250 did not sign the statement. Review of an undated, handwritten statement reported to have been completed by LPN #131, revealed at approximately 11:00 P.M. on 06/13/25 CNA #169 asked LPN #131 if CNA #250 had notified her of any kind of incident involving Resident #54. LPN #131 stated no notifications had occurred. CNA #169 reported to LPN #131 that CNA #250 had requested assistance from CNA #169 to transfer Resident #54 from the floor to the bed. When CNA #169 entered Resident #54's room, there was a mechanical lift sling observed under Resident #54. CNA #169 and #250 transferred Resident #54 from the floor to the bed. LPN #131 stated she went to assess Resident #54 and asked Resident #54 what happened, but Resident #54 was unable to recall what had happened. Resident #54 had no complaints of pain and vital signs were within normal limits. LPN #131 stated she palpated up and down both of Resident #54's legs to determine if this caused pain and Resident #54 denied pain. LPN #131 stated at shift change, CNA #169 asked if CNA #250 had notified her of pain reported by Resident #54. LPN #131 had not been notified but went to reassess Resident #54. LPN #131 palpated Resident #54's hips which resulted in pain in the right hip. LPN #131 notified the on-call physician and received an order for a stat x-ray of the right leg and pelvis. The DHS and family were notified as well. LPN #131 reported to the oncoming day shift nurse (LPN #255) of the new orders for Resident #54. There were no further statements obtained by the facility for review. There was no additional investigation information provided by the facility when requested. An interview on 07/23/25 at 2:15 P.M. with the Assistant Director of Health Services (ADHS) revealed to her knowledge, Resident #54 had been leaning forward in the wheelchair attempting to unhook the catheter drainage bag from the wheelchair when she fell forward out of the wheelchair. The ADHS denied evidence of reported pain initially by Resident #54 and she was transferred into bed by the CNAs. The ADHS revealed she did not believe Resident #54 complained of pain until the following morning on 06/14/25 when an x-ray was ordered and Resident #54 was transferred to the hospital for further evaluation and treatment. However, the ADHS revealed the expectation of the staff would be to not move a resident until the nurse has assessed the resident for injuries and there were no indications of pain from the resident. On 07/24/25 at 1:45 P.M. interview with the ED verified the previous DHS completed the investigation and the ED was unaware of the outcome of the investigation for this incident involving (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #54. The ED stated she was informed the resident was without pain until the morning after the fall. However, the facility was unable to provide any evidence to support a thorough investigation was completed and also verified the resident's medical record did not have documentation of the incident until 06/14/25 at 6:37 A.M. and 6:51 A.M. and did not accurately reflect the date and time of the incident. Interview on 07/24/25 at 10:47 A.M. with CNA #250 confirmed Resident #54 was observed on the floor in her room (on 06/13/25) and CNA #169 and #250 transferred Resident #54 using a mechanical lift from the floor to her bed without LPN #131 assessing for injuries or approving the resident to be moved. CNA #250 stated Resident #54 appeared to be in pain and when asked what Resident #54 wanted to do she kept stating I don't know. CNA #250 stated he had gone to the nurse's desk where LPN #131 and CNA #169 were sitting and reported Resident #54 had fallen and he needed assistance getting her back in bed. CNA #250 stated Resident #54 was a larger lady and he could not move her without assistance, so CNA #169 assisted with the use of the Hoyer lift to transfer Resident #54 back to bed after the fall. The CNA stated Resident #54 was complaining of pain again but could not report where the pain was located. When Resident #54 was placed in bed her complaints of pain stopped and she stated, I feel better. The CNA stated Resident #54 slept through the night and CNA #250 only emptied the resident's urinary catheter drainage bag during the night. Resident #54 did complain of pain early in the morning and CNA #250 said he reported this to the nurse. The CNA revealed on 06/14/25, the DHS interviewed him concerning the incident with Resident #54 and he explained what had occurred. CNA #250 stated several days after this incident, he quit employment at the facility because he felt the facility was trying to blame him for what had occurred. Review of CNA #250's employee file revealed a resignation date of 06/16/25. Attempts to contact LPN #131, previous DHS, CNA #169 and Nurse Practitioner #260 for interviews were unsuccessful. No return contact was made. Review of the facility policy titled Falls dated 07/2021 revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of the undated facility policy titled Change in a Resident's Condition or Status, revealed the facility notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental conditions and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.). The nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. This deficiency represents non-compliance investigated under Complaint Number OH001378148.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and facility policy review the facility failed to ensure fall interventions were implemented. This deficient practice affected one resident (Resident #61) out of four residents reviewed for accidents and hazards. The facility census was 65. Findings Include: Review of the medical record for Resident #61 revealed an admission date of 06/01/22 with diagnoses including but not limited to Parkinson's disease, dementia, chronic kidney disease, and depression. Review of Resident #61's Minimum Data Set (MDS) dated [DATE] revealed Resident #61 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of two out of possible 15. Resident #61 required assistance from staff for transfers and Resident #61 used a walker and wheelchair for assistance for mobility. Review of Resident #61's assessments revealed a fall risk assessment was completed on 07/07/25 and 07/13/25 with Resident #61 being identified as high risk for falls. Review of Resident #61's fall care plan dated 03/05/25 revealed the following fall interventions to be implemented including; night light in the bathroom, non-skid footwear worn, perimeter mattress, touch pad call light, call before you fall sign, low bed, and call light marked with bright colored tape. An observation on 07/23/25 at 8:42 A.M. revealed the following fall interventions were not in place in Resident #61's room, there was no call before you fall sign and there was no bright colored tape on the call light. An interview on 07/23/25 at 11:36 A.M. with Licensed Practical Nurse (LPN) #184 confirmed there was no call before you fall sign and there was no bright colored tape on the call light for Resident #61. Review of the facility's policy titled Falls dated 07/2021 revealed Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from failing.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on medical record review and interview, the facility failed to ensure physician ordered nutritional interventions were implemented for residents with significant weight loss and dietician recommendations were addressed. This affected one resident (Resident #17) of two residents reviewed for nutrition. The facility census was 65. Findings include: Review of Resident # 17's medical record revealed an admission date of 11/19/24 with diagnosis including dementia without behavioral disturbance, type 2 diabetes mellitus, chronic kidney disease stage 3, anxiety disorder, and major depressive disorder. Review of the medical record revealed the Resident #17 experienced a 41-pound significant weight loss (24.4%) from December 2024 through July 2025. The resident's weights were as follows: 12/16/24 172 pounds No January 2025 weight 02/04/25 167.5 pounds 03/01/25 168.8 pounds 04/01/25 147.8 pounds 05/01/25 147.8 pounds 05/30/25 138.8 pounds 06/21/25 130 pounds 07/01/25 128.8 pounds Review of the risk for altered nutritional status related to dementia and depression, chronic kidney disease, significant weight loss, poor intakes, refusing meals with further decline expected care plan with interventions including administer supplements per orders, speech and language pathology (SLP) referral/evaluation/treatment as needed. Further review of the medical record revealed the following: A dietary progress note dated 04/03/25 at 9:55 A.M. revealed the resident's current weight was 147.8 pounds and experienced a 21-pound weight loss (12.4 %) in a month. The dietician documented to add supplements and recommend an appetite stimulant. Review of the dietary recommendation dated 04/03/25 revealed add MedPass (supplement) 120 cubic centimeters (cc) twice a day. (This recommendation was not addressed). A dietician recommendation dated 05/01/25 for an SLP evaluation and increase MedPass to three times a day. Review of the physician orders revealed an order dated 05/03/25 for an SLP evaluation and MedPass 120 cc three times a day. Review of a dietary progress note dated 05/08/25 at 8:19 A.M. revealed the resident weighed 135.2 pounds and she had experienced a 13-pound weight loss in the last 30 days and a 33.6 pounds (19.9%) weight loss during comparison. The dietician recommended an SLP evaluation for the identified significant weight loss. A dietary progress note dated 06/05/25 at 12:02 P.M. revealed the resident had experienced a 25-pound weight loss or 22.1% in the last 180 days. On supplements for weight maintenance. No recommendations were made. Further review of the medical record revealed the MedPass was not provided to Resident #17 from 06/07/25 through 07/03/25. There was no order to discontinue the MedPass but the resident's MedPass was discontinued during that time. A dietary progress note dated 07/03/25 at 9:19 A.M. revealed the resident had experienced 24.4 % weight loss or 42 pounds and would recommend increasing her sugar free supplements. Review of the physician orders revealed MedPass 120 cc three times a day was ordered on 07/03/25. There was no evidence in the medical record to support the SLP evaluation had been completed. On 07/24/25 at 2:48 P.M. interview with Therapy Director #200 verified the SLP evaluation had not been completed as ordered. On 07/24/25 at 3:20 P.M. an interview with the Assistant Director of Nursing (ADON) #152 verified there was an order for an SLP evaluation written on 05/03/25 but the evaluation had not been completed. The ADON also verified MedPass was initially ordered on 05/03/25 but was discontinued from documentation on 06/07/25 and was not administered until the MedPass was re-ordered on 07/03/25. The ADON verified the significant weight loss experienced by Resident #17.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and policy review the facility failed to ensure non-pharmacologic pain interventions were implemented prior to the administration of as needed pain medication. This affected two residents (#25 and #45) of three residents reviewed for pain management. Findings include: 1. Review of Resident # 45's medical record revealed that he was admitted on [DATE] with diagnoses that included myocardial infarction, spinal stenosis, diabetes, post laminectomy syndrome, diabetes mellitus type 2, and chronic venous insufficiency. Review of Resident #45's Minimum Data Set Assessment, dated 5/20/25 revealed that he was dependent on staff for toileting hygiene and transfers and his BIMS score was 15. Review of Resident #45's Physicians' orders revealed an order for Oxycodone HCl Oral Tablet 15mg; Give 1 tablet by mouth every 6 hours for pain. There was no order for non- pharmacological interventions for his pain medication. Review of Resident #45's Medication Administration Record, dated July 2025, revealed that he had received oxycodone 15mg daily every 6 hours as ordered. There was no indication of any non-pharmacological interventions attempted prior to administration of his pain medication. Review of Resident #45's care plans, dated 07/01/25 revealed an at risk for pain care plan with an intervention that included: Offer non-pharmacological interventions to relieve pain and monitor for effectiveness: like distraction technique, relaxation and breathing exercises, music therapy and repositioning. Interview on 07/23/25 at 2:37 P.M. with LPN (Licensed Practical Nurse) #173 confirmed there were no non-pharmacological interventions for pain medications. 2. Review of Resident # 25's medical record revealed that she was admitted on [DATE] with diagnosis including cerebral infarction due to occlusion or stenosis of small artery, Parkinson's Disease, congestive heart failure, chronic obstructive pulmonary disease, acute respiratory failure, and repeated falls. Review of Resident #25's Minimum Data Set Assessment, dated 5/23/25 revealed intact cognition. Review of Resident #25's Physicians' orders revealed an order for Norco 5/325mg (milligrams) every six hours as needed, give one tablet by mouth every six hours for pain and Tylenol give 650mg every eight hours as needed for pain. There were no orders for non- pharmacological interventions for her pain medications. Review of Resident #25's Medication Administration Record, dated July 2025 and June 2025, revealed that she had received Norco 5/325 mg as needed and Tylenol 659mg as needed. There was no indication of any non- pharmacological interventions attempted prior to administration of his pain medication. Review of Resident #25's care plans, dated 06/20/25 revealed an at risk for pain care plan with an (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention that included: offer non-pharmacological interventions to relieve pain and monitor for effectiveness: like distraction technique, relaxation and breathing, exercises, music therapy, repositioning- if resident will accept. Interview on 07/23/25 at 2:37 P.M. with LPN #173 confirmed there were no non-pharmacological interventions for pain medications. 3. Review of Resident #61 medical record revealed admission date 06/01/22 with diagnoses including but not limited to Parkinson's Disease, dementia, depression and chronic kidney disease. Review of Resident #61's significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #61 had severely impaired cognition with a Brief Interview Mental Status (BIMS) score of two out of a possible 15 and was not receiving any scheduled or as needed (PRN) pain medication. Review of Resident #61's physician orders revealed an order dated 07/14/25 for topical pain medication patch Lidocore External Patch (Lidocaine) apply to right ribs topically for pain for 14 days on in the morning and off at bedtime, an order for Morphine Sulfate (concentrate) solution 20 milligrams (mg) per milliliters (ml) give 0.25 ml by mouth every 2 hours as needed (PRN) for pain, and an order dated 05/22/25 for admission to Shriver's Hospice for malnutrition. Review of Resident #61's Medication Administration Record (MAR) dated 07/01/25 to 07/23/25 revealed Morphine Sulfate (concentrate) solution 20 milligrams (mg) per milliliters (ml) give 0.25 ml by mouth every 2 hours as needed (PRN) was administered on 07/14/25 and on 07/15/25 for pain. There were no non-pharmacological pain interventions attempted and/or documented prior to the administration of the pain medication Morphine. Review of Resident #61's pain care plan dated 07/15/25 revealed to offer non-pharmacological interventions to help relieve pain and to monitor effectiveness of interventions and medications. An interview on 07/23/25 at 1:28 P.M. with the Assistant Director of Health Services (ADHS) confirmed there were no non-pharmacological pain interventions attempted and/or documented for Resident #61 prior to the administration of pain medications. The ADHS stated the expectations for nurses are to offer non-pharmacological interventions to residents which may offer pain management/relief prior to medication administration. Review of the facility's policy titled Pain Assessment and Management dated 07/2021 revealed The pain management interventions shall be consistent with the resident's goals for treatment. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Review of the facility's policy titled Pain Assessment and Management dated 07/2021 revealed The pain management interventions shall be consistent with the resident's goals for treatment. Non-pharmacological interventions may be appropriate alone or in conjunction with medications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure infection control guidelines were maintained during a dressing change. This affected one resident (Resident #47) of one residents observed for dressing changes. The facility census was 65. Findings include: Medical record review revealed Resident #47 was admitted on [DATE] with diagnosis including chronic obstructive pulmonary disease, chronic respiratory failure, and hypertension. Review of the physician orders revealed to cleanse the sacral wound with normal saline and apply triad paste and a large dry dressing daily. On 07/23/25 at 8:00 A.M. a dressing change was observed for Resident #47 with Nurse # 129 and the Assistant Director of Nursing #152 completing the resident care. Nurse #129 assisted Resident #47 with pulling her pants down to expose the old dressing and removed the dressing. Nurse #129 proceeded to remove her gloves, perform hand hygiene and donned a new pair of clean gloves. Nurse #129 cleansed the wound with normal saline using a 4x4 gauze and removed her gloves to perform hand hygiene leaving the residents pants touching the wound after cleansing. Nurse #129 donned a new set of clean gloves, pulled Resident #47s pants down exposing her wound and applied Triad paste using a sterile cotton tip applicator and covered the wound with a dressing. Interview on 07/23/25 at 8:25 A.M. with ADON #152 and LPN #129 confirmed Resident #47's pants re-contaminated the wound after cleansing, Nurse#129 stated she did not want to leave the resident exposed while changing her gloves.		