

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Tuscany Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 Hazelton Etna Road SW Pataskala, OH 43062	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on interview and medical record review the facility failed to report an allegation of resident-to-resident sexual abuse. This affected one (Resident #12) of three residents reviewed for abuse. The facility census was 112.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #12 revealed an admitted [DATE]. Diagnoses included dementia, unspecified sequelae of cerebral infarction, and moderate protein calorie malnutrition.</p> <p>Review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had a memory problem and had severe cognitive impairment.</p> <p>Review of Resident #12's nursing progress noted from 04/2024 revealed nothing related to inappropriate resident contact.</p> <p>Review of Resident #16's medical record revealed an admitted [DATE]. Diagnoses included dementia, hypertension, and primary open-angled glaucoma. His April 2024 orders revealed an order for a Wandergaurd to is right ankle. Review of his quarterly MDS assessment dated [DATE] revealed a moderate cognitive impairment. Review of his care plan revealed no evidence of the resident having sexual behavior.</p> <p>Review of Resident #16's nursing progress notes revealed a note dated 04/22/24 at 5:04 P.M. which stated, Resident was seen by one of the aides fondling one of the resident's breasts. This nurse notified the unit manager and redirected resident.</p> <p>Interview on 05/02/24 at 11:07 A.M. State tested Nurses Aide (STNA) #203 revealed Resident #16 wanders around the unit quite a bit. He will go into other rooms. STNA #203 stated she has witnessed the resident fondling Resident #12 in the past. She went on to say she does have to frequently redirect him away from Resident #12. STNA #203 revealed she has never been required to provide statements or receive formal training on how to appropriately treat his behaviors.</p> <p>(continued on next page)</p>		

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/02/24 at 11:18 A.M. with STNA #204 revealed she was told by the nurses to try to keep Resident #16 away from Resident #12 because he was observed inappropriately touching her. She reported, at times, it takes constant redirection to keep him separated from her. She stated she has witnessed him inappropriately touching residents in the facility and has told the nurse before. She stated she has never been required to provide statements or received formal training on how to appropriately treat his behaviors.</p> <p>Interview on 05/02/24 at 2:44 P.M. with the facility Director of Nursing (DON) reported that on 04/22/24 she received a report that an STNA witnessed Resident #16 fondle Resident #12's breasts. She reported both residents are cognitively impaired. She stated a skin assessment was completed and no injuries were noted. She stated that if the incident does not cause physical harm or change in psychosocial status the facility does not notify the state agency.</p> <p>Review of the facility's, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated 11/21/16 revealed it is the facility's policy to investigate all alleged violations involving Abuse, Neglect, Exploitation, and Misappropriation of Resident Property. Additionally, the facility should immediately report all such allegations to the administrator and to the state survey agency. The policy went on to identify sexual abuse is nonconsensual sexual contact of any type with a resident.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153480.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on interview and medical record review the facility failed to thoroughly investigate an allegation of resident-to-resident sexual abuse. This affected one (Resident #12) of three residents reviewed for abuse. The facility census was 112.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #12 revealed admitted [DATE]. Diagnoses include dementia, unspecified sequelae of cerebral infarction, and moderate protein calorie malnutrition.</p> <p>Review of Resident #12's quarterly Minimum Data Set assessment dated [DATE] revealed she had a memory problem and had severe cognitive impairment.</p> <p>Review of Resident #12's nursing progress noted from 04/2024 revealed nothing related to inappropriate resident contact.</p> <p>Review of Resident #16's medical record revealed an admitted [DATE]. Diagnoses included dementia, hypertension, and primary open-angled glaucoma. His April 2024 orders revealed an order for a Wandergaurd to is right ankle. Review of his quarterly MDS assessment dated [DATE] revealed a moderate cognitive impairment. Review of his care plan revealed no evidence of the resident having sexual behavior.</p> <p>Review of Resident #16's nursing progress notes revealed a note dated 04/22/24 at 5:04 P.M. which stated, Resident was seen by one of the aides fondling one of the resident breasts. This nurse notified the unit manager and redirected resident.</p> <p>Interview on 05/02/24 at 11:07 A.M. with State tested Nurses Aide (STNA) #203 revealed Resident #16 wanders around the unit quite a bit. He will go into other rooms. STNA #203 stated she has witnessed the resident fondling Resident #12 in the past. She went on to say she does have to frequently redirect him away from Resident #12. STNA #203 revealed she has never been required to provide statements or received formal training on how to appropriately treat his behaviors.</p> <p>Interview on 05/02/24 at 11:18 A.M. with STNA #204 revealed she was told by the nurses to try to keep Resident #16 away from Resident #12 because he was observed inappropriately touching her. She reported, at times, it takes constant redirection to keep him separated from her. She stated she has witnessed him inappropriately touching residents in the facility and has told the nurse before. She stated she has never been required to provide statements or received formal training on how to appropriately treat his behaviors.</p> <p>Interview on 05/02/24 at 2:44 P.M. with the facility Director of Nursing (DON) reported that on 04/22/24 she received a report that an STNA witnessed Resident #16 fondle Resident #12's breasts. She reported both residents are cognitively impaired. She stated a skin assessment was completed and no injuries were noted. She confirmed a formal investigation was not completed, interviews were not conducted, other residents were not assessed, and Resident #16's care plan was not updated to address his new sexual behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated 11/21/16 revealed it is the facility's policy to investigate all alleged violations involving Abuse, Neglect, Exploitation, and Misappropriation of Resident Property. Additionally, the facility should immediately report all such allegations to the administrator and to the Ohio Department of Health. The policy went on to identify sexual abuse is nonconsensual sexual contact of any type with a resident.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153480.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on interview and record review the facility failed to ensure an investigation and appropriate corrective action was implemented after staff used a mechanical lift incorrectly. This affected one (Resident #13) of three residents reviewed for accidents. The facility census was 112.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnosis included hemiplegia and hemiparesis following a cerebral infarction, stiffness of the left hip, ataxia, and Moyamoya.</p> <p>Review of Resident #13's physician orders revealed an order dated 02/28/23 that stated the facility may utilize Hoyer lift for transfers as needed for weakness/difficulty transferring.</p> <p>Review of Resident #13's progress notes from 03/01/24 through 03/31/24 revealed no notes related to the incident. A note on 03/11/2024 at 10:18 P.M. revealed that neurological (Neuro) checks continue as ordered.</p> <p>Review of her Quarterly Minimum Data Set (MDS) dated [DATE] revealed she has intact cognition and required staff assist for transfers.</p> <p>Interview on 05/02/24 at 10:25 A.M. with Resident #13 revealed a few weeks ago, a State tested Nurses Aide (STNA) #100 was transferring her in a Hoyer lift independently when the Hoyer lift tipped and fell on top of the resident and hit her in the head. She reported two staff members are supposed to use the lift when transferring her but sometimes only one staff will do it. She stated that her head hurt for a little while, but the pain did not last long.</p> <p>Review of Review of Registered Nurse (RN) #200 witness statement dated 03/11/24, revealed 11:30 A.M. this morning STNA #100 approached her and informed her that the Hoyer lift fell on Resident #13. RN #200 quickly rushed to the resident's room to help. RN #200 and STNA #100 were not able to get the Hoyer lift from the resident, so she called one more STNA to help. RN #200 stated she saw the resident sitting in her wheelchair and the Hoyer was on top of her, they were able to get the Hoyer off the resident. RN #200 stated she notified the unit manager RN #201 and also informed the resident's Power of Attorney about the incident. A head-to-toe assessment was done with no injury noted. Acetaminophen was administered due to the resident's complaint of a headache. Neuro checks are in progress and this report has been passed to the night shift nurse to continue to monitor on resident.</p> <p>Interview on 05/02/24 at 2:24 P.M. with Human Resources Manager (HRM) #202 revealed on 03/11/24 she wrote up and suspended STNA #100 for using a Hoyer lift by herself and for being insubordinate at her inquiry into the incident. She stated STNA #100 refused to sign the discipline. She continued that she was suspended for one day and then permitted to come back to work. HRM #202 went on to say STNA #100 was not retrained on the proper use of a Hoyer lift to her knowledge before returning to work but did report that she had previous training upon hire.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/02/24 at 12:20 P.M. with the facility's Director of Nursing (DON) stated on 03/11/24 STNA #100 transferred Resident #13 by herself using a Hoyer lift. She reported that Hoyer transfers always require two staff to transfer the resident safely. The DON went on to say while transferring the resident the Hoyer lift fell on the resident hitting her in the head. She stated she was assessed, and no injury was noted so she did not complete an incident report or investigation including interviews with staff present, interview with the resident, or retraining of proper Hoyer lift techniques. She stated STNA #100 was disciplined but was permitted back to the facility without reeducation on the proper use of a Hoyer lift.</p>		