

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 06/02/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and resident interview, the facility failed to protect the resident from abuse by staff. This affected one (Resident #54) of four resident records reviewed for abuse. The census was 105.</p> <p>Findings include:</p> <p>Review of Resident #54's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, morbid obesity, major depression, peripheral vascular disease, anxiety, reduced mobility and anxiety.</p> <p>Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed her cognition was intact. She required set up or clean up assistance with oral hygiene, she is dependent for toileting, and requires substantial/maximal assistance for shower/bathing, dressing, personal hygiene and turning and repositioning. She is always incontinent of urine and frequently incontinent of bowel.</p> <p>Review of the plan of care she experiences alteration in mood and/or behavior as evidenced by resident has diagnoses of depression feeling bad about self or feeling like a failure, Feeling down/depressed/hopeless, feeling tired or having little energy, feels lonely or isolated, having difficulty concentrating, poor appetite or overeating, showing little interest/pleasure in doing things.</p> <p>Review of the Self Reported Incidents's revealed no reports of abuse.</p> <p>On 5/6/2025 at 10:53 A.M. revealed a progress note that revealed the nurse along with Certified Nurses Aide (CNA) were assisting resident into a sitting position from a lying position in order to utilize sit-to-stand machine. CNA took a hold of residents left hand and skin tear occurred due to residents fragile skin. The nurse immediately assessed residents pain level, resident denied any pain or discomfort upon questioning. The area was measured at 2.5 centimeters (cm) x 0.5 cm. Area was cleansed with normal saline, patted dry and steri-strips were applied and secured with a cover dressing. Intervention; Encourage resident use of geri-sleeves. Treatment in place; top of left hand: Cleanse Skin Tear with Normal Saline, pat dry with gauze. Apply primary dressing: Cover dressing. Allow steri-strips to fall off naturally. Change daily and as needed. Wound nurse to assess on Sunday. Nurse Practitioner and daughter was made aware of the same.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366353
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a statement by CNA #205 revealed on 05/11/25 revealed CNA #10 dropped Resident #54 from the hoyer into the shower chair from at least one foot in the air. CNA #205 told CNA #10 you can't do that and the CNA #10 said sorry, I hope you didn't hurt yourself. Also Resident #54 was unfamiliar with the hoyer lift and wasn't sure how the hoyer pad was supposed to fit. She asked if it was supposed to be under her neck or behind her head. The CNA #10 without saying a word, reached up and violently yanked the hoyer pad to straighten it out causing the Resident #54's head to snap back.</p> <p>On 06/02/24 at 10:38 A.M., Interview with Resident #54 revealed most staff are very good and kind but there are exceptions. She stated she had been at facility for two and a half years and off the top of her head there had only been one exception, CNA #10. She stated CNA #10 does not take care of her anymore. She stated CNA #10 was not a nice person, she grabbed her by arm when she had a rubber glove on and was helping her turn to get up and caused a skin tear on her arm. She stated she has thin skin. She then stated the aides were putting her in the shower chair with the Hoyer lift (for the first time), they usually use a sit to stand, and she let it down too fast and it scared her. She didn't get hurt. (Resident showed she was about 10 inches from the shower chair) she revealed another staff member was with her. She stated CNA #10 was doing her care once and pulled her hair and stated she didn't know if it was on purpose or an accident. She stated she told on her and she is no longer allowed in her room or to take care of her. She works day shift.</p> <p>On 06/02/25 at 11:12 A.M., interview with the Director of Nursing (DON) revealed one family did ask that the CNA #10 did not take care of their mother any longer. They felt she had an attitude and rough with transfers. There were two CNA's for the transfer. When asked about the skin tear she revealed she had another CNA with her when that happened and it happened when they were getting her up with the sit to stand. Asked about her pulling her hair and she revealed she was never told this. CNA #10 was moved and educated and we have had no other complaints about her. The facility has no hoyer lift policy and procedure.</p> <p>On 06/02/25 at 11:41 A.M., interview with CNA #205 revealed CNA #10 and her were getting Resident #54 up in a shower chair, CNA #205 was holding her back with the hoyer pad so CNA #10 could lower her and she hit the emergency drop button. Resident #54 was about 10 inches from chair. I told her you can't do that. Resident #54 let out a [NAME] but no complaints of injury. Then a couple hours later I was helping to get her back up after CNA #10 had changed her and the Hoyer pad was bunched up under her neck and Resident #54 asked if it was supposed to be like that, she grabbed it and jerked the pad up and her head went back, No complaints of any pain or injury. CNA #10 was very rude and uncaring, not friendly. Felt she was being abusive. The daughter was there at the time. CNA #205 stated she did report it to Registered Nurse (RN) #239 and had to write a statement. Another family also asked for CNA #10 not to take care of their family member Resident #48 because she was rude to her and the family.</p> <p>On 06/02/25 at 12:56 P.M., interview with the Resident #54's daughter revealed she was worried about her mom's safety with CNA #10. The other staff have been tremendous. Wouldn't have her anywhere else. It just feels off with her. Like on mothers day she asked her to get her mom up so we could talk and she said I'm to busy. Everyone bends over backward for mom. I trust them to take care of mom. I feel they have it under control.</p> <p>On 06/02/25 at 1:02 P.M., interview with Resident #54 revealed she was afraid of CNA #10.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/02/25 at 1:11 P.M., interview with the DON revealed the Administrator said he did not report the allegation because it was not alleged abuse. This deficiency represents non-compliance investigated under Complaint Number OH00166084.		