

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 03/13/2026
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observations and interview with staff, the facility failed to ensure privacy was maintained during medication administration for Resident #21, #52, #77 #84, #85, and #88. This affected six residents (#21, #52, #84, #85, and #88) of 14 observed for medication administration. Findings Include:</p> <p>1. Review of the medical record for Resident #85 revealed an admission date of 01/05/26 and diagnoses of diabetes, muscle weakness, cognitive communication deficit, need for assistance with personal care, high blood pressure, constipation, and congestive heart failure. Observation of medication administration on 03/13/26 at 11:35 A.M. revealed Registered Nurse #201 prepared medication at the medication cart outside the room of Resident #85. She proceeded to go into the room of Resident #85 without locking the screen of the computer leaving personal health information for Resident #85 in view for anyone to see. The information in view included the residents name, room number, diagnoses and medications. On 03/13/26 at 11:44 A.M. an interview with Registered Nurse #201 verified she had not locked the computer screen to protect Resident #85's personal health information.</p> <p>2. Review of the medical record for Resident #77 revealed an admission date of 10/16/19 and diagnoses of eating disorder, cerebral palsy, acute kidney failure, gastrointestinal hemorrhage, anxiety disorder, constipation, and contact with and suspected exposure to viral communicable diseases. Observation of medication administration on 03/13/26 at 11:42 A.M. revealed Registered Nurse #201 prepared medication at the medication cart outside the room of Resident #77. She proceeded to go into the room of Resident #77 without locking the screen of the computer leaving personal health information for Resident #77 in view for anyone to see. The information in view included the residents name, room number, diagnoses and medications. On 03/13/26 at 11:44 A.M. an interview with Registered Nurse #201 verified she had not locked the computer screen to protect Resident #77's personal health information.</p> <p>3. Review of the medical record for Resident #21 revealed an admission date of 09/27/25 and diagnoses of diabetes, malignant neoplasm of pancreatic duct and kidney, depression, and congestive heart failure. Observation of medication administration on 03/13/26 at 1:34 P.M. revealed Registered Nurse #200 prepared medication at the medication cart outside the room of Resident #21. She proceeded to go into the room of Resident #21 without locking the screen of the computer leaving personal health information for Resident #21 in view for anyone to see. The information in view included the residents name, room number, diagnoses and medications. On 03/13/26 at 2:03 P.M. an interview with Registered Nurse #200 verified she had not locked the computer screen to protect Resident #21's personal health information.</p> <p>4. Review of the medical record for Resident #88 revealed an admission date of 04/15/24 and diagnoses of anxiety, dementia, neuromuscular dysfunction of the bladder, slow transit constipation, and depression. Observation of medication administration on 03/13/26 at 1:38 P.M. revealed Registered Nurse #200 prepared medication at the medication cart outside the room of Resident #88. She proceeded to go into the room of Resident #88 without locking the screen of the computer leaving personal health information for Resident #88 in view for anyone to see. The information in view included the residents name, room number, diagnoses and medications. On 03/13/26 at 2:03 P.M. an interview with Registered Nurse #200 verified she had not locked the computer screen to protect Resident #88's personal health information.</p> <p>5. Review of the medical record for Resident #84 revealed an admission date of 09/01/21 (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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>and diagnoses of dementia, urinary tract infection, depression, constipation, and urine retention. Observation of medication administration on 03/13/26 at 1:43 P.M. revealed Registered Nurse #200 prepared medication at the medication cart outside the room of Resident #84. She proceeded to go into the room of Resident #84 without locking the screen of the computer leaving personal health information for Resident #84 in view for anyone to see. The information in view included the residents name, room number, diagnoses and medications. On 03/13/26 at 2:03 P.M. an interview with Registered Nurse #200 verified she had not locked the computer screen to protect Resident #84's personal health information. 6. Review of the medical record for Resident #52 revealed an admission date of 02/17/26 and diagnoses of depression, altered mental status, urine retention, high blood pressure, constipation, and congestive heart failure. Observation of medication administration on 03/13/26 at 1:46 P.M. revealed Registered Nurse #200 prepared medication at the medication cart outside the room of Resident #52. She proceeded to go into the room of Resident #52 without locking the screen of the computer leaving personal health information for Resident #52 in view for anyone to see. The information in view included the residents name, room number, diagnoses and medications. On 03/13/26 at 2:03 P.M. an interview with Registered Nurse #200 verified she had not locked the computer screen to protect Resident #52's personal health information.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the medical record, review of the Controlled Drug record, and interview with the staff, the facility failed to ensure the Controlled Drug record and the narcotic count were maintained to identify the actual doses of oxycodone/acetaminophen (a controlled narcotic medication) in the facility and failed to ensure staff did not pre-pour narcotic medication prior to administration for Resident #9. This affected one Resident (#9) of 14 observed for medication administration. Findings Include: Review of the medical record revealed Resident #9 was admitted to the facility on [DATE]. Diagnoses included mood disorder, bipolar disorder, anemia, diabetes, mild cognitive impairment, chronic pain, dementia, insomnia, cataracts, absence of a spleen, and follicular disorder. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #9 had intact cognition. Review of Resident #9's physician orders revealed an order dated 07/18/25 for oxycodone acetaminophen 10/325 milligrams with instructions to administer one tablet four times per day for pain. Review of the Controlled Drug Record-Disposition form on 03/13/26 for the oxycodone-acetaminophen for Resident #9 revealed he should have had 13 tablets of oxycodone-acetaminophen left however the medication card in the narcotic drawer only had 12 tablets left. Observation of medication administration on 03/13/26 at 11:48 A.M. revealed Registered Nurse #201 retrieved an oxycodone acetaminophen 10/325 milligrams out of the locked medication cart for Resident #9. The count remaining on the card was 12 tablets. Registered Nurse #201 proceeded to sign the dose out however the record indicated there should have been 13 doses remaining. The record indicated one tablet was administered, for the future, at 12:00 P.M. on 03/13/26 for 13 tablets and one administered, for the future, at 5:00 P.M. on 03/13/26 for 12 tablets left however both were errored out and initialed by Registered Nurse #201. On 03/13/26 at 11:55 A.M. an interview with Registered Nurse #201 revealed she had wasted a dose of oxycodone acetaminophen earlier in the day and did not have anyone witness or sign for it. A supervisor was called at this time to report the discrepancy. On 03/13/26 at 12:44 P.M. an interview with Regional Clinical Nurse #300 revealed Registered Nurse #201 had not told the surveyor the truth about what had happened to the narcotic. On 03/13/26 at 12:45 P.M. an interview with Registered Nurse #201 revealed she had pre-poured the dose of oxycodone acetaminophen for Resident #8 and it was in the top drawer of the medication cart and she was scared to tell the surveyor the truth. She stated she was trying to get ahead because Fridays were crazy with admissions and the nurse practitioner rounding. She stated she had pre-poured medications and signed them out for the whole shift. She verified she errored them out when she found out she would be observed for medication administration.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation and interview with staff, the facility failed to ensure the medication carts were locked when unattended. This had the potential to affect 9 (#17, #34, #40, #50, #57, #59, #63, #87, and #93) cognitively impaired and independently mobile residents, on the 200 and 300 halls, identified during the survey. Findings Include: 1. Observation of medication administration on 03/13/26 at 11:35 A.M. revealed Registered Nurse #201 prepared medication at the medication cart outside the room of Resident #85. She proceeded to go into the room of Resident #85 without locking the medication cart. On 03/13/26 at 11:44 A.M. an interview with Registered Nurse #201 verified she had not locked the medication cart. 2. Observation of medication administration on 03/13/26 at 11:42 A.M. revealed Registered Nurse #201 prepared medication at the medication cart outside the room of Resident #77. She proceeded to go into the room of Resident #77 without locking the medication cart. On 03/13/26 at 11:44 A.M. an interview with Registered Nurse #201 verified she had not locked the medication cart. 3. Observation of medication administration on 03/13/26 at 1:34 P.M. revealed Registered Nurse #200 prepared medication at the medication cart outside the room of Resident #21. She proceeded to go into the room of Resident #21 without locking the medication cart. On 03/13/26 at 2:03 P.M. an interview with Registered Nurse #200 verified she had not locked the medication cart. 4. Observation of medication administration on 03/13/26 at 1:38 P.M. revealed Registered Nurse #200 prepared medication at the medication cart outside the room of Resident #88. She proceeded to go into the room of Resident #88 without locking the medication cart. On 03/13/26 at 2:03 P.M. an interview with Registered Nurse #200 verified she had not locked the medication cart. 5. Observation of medication administration on 03/13/26 at 1:43 P.M. revealed Registered Nurse #200 prepared medication at the medication cart outside the room of Resident #84. She proceeded to go into the room of Resident #84 without locking the medication cart. On 03/13/26 at 2:03 P.M. an interview with Registered Nurse #200 verified she had not locked the medication cart. 6. Observation of medication administration on 03/13/26 at 1:46 P.M. revealed Registered Nurse #200 prepared medication at the medication cart outside the room of Resident #52. She proceeded to go into the room of Resident #52 without locking the medication cart. On 03/13/26 at 2:03 P.M. an interview with Registered Nurse #200 verified she had not locked the medication cart.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview, and review of facility policy, the facility failed to maintain proper infection control during administration of tube feed medications for Resident #15. This affected one resident (Resident #15) of 14 observed during medication administration. Findings Include: Review of the medical record revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, chronic obstructive pulmonary disease, anemia, hypothyroidism, gastrostomy, major depressive disorder, generalized anxiety disorder, hallucinations, schizoaffective disorder, adult failure to thrive, and dementia. Review of the Annual Minimum Data Set assessment dated [DATE] revealed Resident #15 had severely impaired cognition and had a feeding tube. Observation of tube feed medication administration on 03/13/26 at 9:58 A.M. revealed Licensed Practical Nurse (LPN) #202 went into the room of Resident #15, obtained the graduated container and syringe (the syringe was inside the graduate with no bag or date) off the bedside table, she went into the bathroom and put 500 milliliters (ml) in the graduate and came back out of the bathroom, and set the cup with the medication and syringe directly on the bedside table without placing a barrier down. The table was visibly dirty. She proceeded to administer the medication with the syringe. On 03/13/26 at 10:20 A.M. an interview with Licensed Practical Nurse #202 verified she had set the syringe directly on the visibly dirty bedside table without a barrier. On 03/13/26 at 1:20 P.M. an interview with Regional Clinical Nurse #300 verified Licensed Practical Nurse #202 should have placed a barrier on the bedside table prior to placing the syringe on the table. Review of the facility policy titled, Enteral Tube Medication Administration, dated 06/11/24 revealed it was the practice of the facility to administer medication through an enteral feeding tube as prescribed and in accordance with current clinical standards of practice.</p>		