

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/24/2025
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)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview and facility policy review, the facility failed to change and date oxygen tubing and supplies as ordered and failed to store respiratory equipment in a safe and sanitary manner. This affected four residents (#38, #44, #71, #82) of four residents reviewed for respiratory care. The census was 99. Findings Include: 1. Review of the medical record for Resident #44 revealed an initial admission date of 05/02/25 with the diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), pulmonary embolism, congestive heart failure, hypertension, chronic kidney disease, hyperlipidemia, gastro-esophageal reflux disease, osteoarthritis, constipation, hypothyroidism, anxiety disorder and chronic respiratory failure. Review of the plan of care dated 05/12/25 revealed the resident has a respiratory deficiencies or abnormalities of pulmonary function related to COPD, history of respiratory failure and oxygen use. Interventions included administer oxygen as ordered, aerosol treatments as ordered, diagnostic studies as ordered, elevate head of bed as needed, medications as ordered, monitor for signs/symptoms of respiratory function, monitor lung sounds as ordered, monitor oxygen saturation as ordered, Monitor/observe if resident is avoiding lying flat related to shortness of breath or trouble breathing, observe for signs/symptoms of dyspnea, oxygen as ordered, provide inhalers as ordered, respiratory assessment as ordered, respiratory medications as ordered, update Physician with any abnormal or new findings for possible evaluation or further treatment as needed, update resident/family as necessary and vital signs as ordered. Review of the resident's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident received oxygen therapy. Review of the resident's monthly physician orders for September 2025 identified orders dated 08/25/25 clean filter on oxygen concentrator every Wednesday on night shift, may use three to four liters of oxygen continuously per nasal cannula to maintain oxygen saturation above 90% every shift, change oxygen tubing/cannula/mask every Wednesday on night shift. Review of the resident's May, June, July, August and September Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no documented evidence the resident's nasal cannula or humidifier bottle was changed weekly. On 09/15/25 at 3:03 P.M. observation of the resident revealed the oxygen nasal cannula was not dated and the humidifier bottle was not dated and empty. On 09/15/25 at 3:15 P.M., an interview with Registered Nurse (RN) #582 verified the nasal cannula had no date and no documented evidence the tubing had been changed since admission to the facility. The RN also verified the humidifier bottle had no date and was empty. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #38 revealed an initial admission date of 01/16/25 with the latest readmission of 08/05/25 with the diagnoses including but not limited to congestive heart failure, diabetes mellitus, hypothyroidism, atrial fibrillation, depression and osteomyelitis of vertebra, lumbar region. Review of the plan of care dated 01/28/25 revealed the resident required oxygen related to congestive heart failure. Interventions included administer oxygen as ordered, change filter on oxygen concentrator per orders, change oxygen tubing, mask and cannula per orders, monitor lung sound as ordered, observe for signs/symptoms of dyspnea and respiratory system observation, monitoring, and data collection of current respiratory deficiencies or abnormalities of pulmonary function, update physician as needed. Review of the resident's quarterly Minimum Data (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident received oxygen therapy. Review of the resident's monthly physician orders for September 2025 identified orders dated 02/05/25 change oxygen tubing/cannula/mask every Wednesday on night shift, change filter on oxygen concentrator weekly every Wednesday on night shift, oxygen at three liters per minute continuous per nasal cannula to maintain saturation above 90% and 04/09/25 check oxygen saturation every shift while on oxygen. On 09/15/25 at 11:21 A.M., observation of the resident revealed the resident's oxygen nasal cannula had no date and the humidifier bottle had no date and was empty. On 09/15/25 at 11:36 A.M., an interview with RN #582 revealed verified the resident's oxygen nasal cannula had no date and the humidifier bottle was not dated and empty. 3. Review of the medical record for Resident # 71, revealed an admission date of 07/21/21. Diagnoses included but were not limited to paralytic syndrome, chronic obstructive pulmonary disease, asthmas, gastroesophageal reflux disease, osteoporosis, pulmonary heart disease, diaphragmatic hernia, allergic rhinitis, dysphagia, peripheral vascular disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating the resident had no cognitive deficit. Review of an order dated 08/06/21, revealed Resident #71 required staff to administer Budesonide Suspension 0.25 milligrams (mg)/2 milliliter (mL) 2 ml inhale orally two times a day for asthma via nebulizer. Further review revealed a physician order dated 02/05/25 to change nebulizer tubing, cannula, and mask on night shift every Wednesday. Observation on 09/15/2025 at 11:39 A.M. Resident #71's nebulizer tubing and mask were lying in an open plastic box on a brown paper towel with no visible date on the tubing or mask. Interview on 09/15/25 at 1:37 P.M. with Registered Nurse (RN) #582 confirmed Resident #71's nebulizer mask and tubing were lying in open plastic box on a brown paper towel. Additionally, RN #582 confirmed the tubing was undated, but should be dated and changed every Wednesday night. Interview on 09/17/25 at 09:30 A.M. with RN Manager of Clinical Services #700 stated there is no policy for nebulizers or tubing and no policy on storing and cleaning nebulizer supplies. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record revealed Resident #82 was admitted on [DATE]. Diagnoses include chronic obstructive pulmonary disease (COPD), type II diabetes mellitus without complications, chronic systolic (congestive) heart failure, and obstructive sleep apnea. Review of Resident #82's Minimum Data Set (MDS) dated [DATE] states Resident #82 had a BIMS of 15 out of 15, cognitively intact and required use of walker or wheelchair and experienced shortness of breath or trouble breathing when laying flat. Review of Resident #82's care plan dated 09/15/25 revealed Resident #82 has respiratory deficiencies related or abnormalities of pulmonary function related to COPD, orthopnea, and SOB on exertion with the goal of reducing the risk of respiratory complications through target date. Interventions include elevate head of bed (HOB) as needed, oxygen as ordered, respiratory assessment as ordered, respiratory medications as ordered, and respiratory therapy treatments are ordered. Review of Resident #82's care plan dated 09/15/25 revealed Resident #82 is at risk for decreased cardiac output and impaired gas exchange related to disease process with goal of Resident lungs will be clear and no SOB on exertion and resident #82 will show adequate cardiac output. Interventions include oxygen as ordered, rest periods as needed, visual reminder to wear oxygen at all times and monitor the effectiveness of interventions. Review of Resident #82's physician orders revealed an order for continuous oxygen at 2-4 L via nasal cannula every shift. Review of Resident #82's physician orders revealed an order to change oxygen tubing/cannula/mask weekly every night shift every Wednesday related to chronic obstructive pulmonary disease. Review of Resident #82's physician orders revealed an order to change nebulizer tubing/mask/cannula weekly every night shift every Wednesday. Review of Resident #82's TAR revealed oxygen tubing was not documented as being changed on 09/03/25. Observation on 09/15/25 at 11:30 A.M. Resident #82 sitting in recliner with oxygen concentrator in use with a undated empty humidifier bottle and no date on oxygen tubing. Observation on 09/15/25 at 11:31 A.M. of Resident #82's bed revealed an uncovered nebulizer mask laying on the bed with the tubing labeled 08/27. Interview on 09/15/25 at 11:30 A.M. with Resident #82. revealed he requires 4L of oxygen Interview on 09/15/25 at 2:00 P.M. with Resident #82 revealed he occasionally requires the use of his nebulizer. Interview on 09/15/25 at 2:05 P.M. with LPN #575 verified the humidifier bottle on Resident #82 was empty, O2 tubing was not dated, and nebulizer mask was uncovered on Resident #82's bed. Review of the facility's policy titled Oxygen Administration revised on 07/30/24 indicates oxygen tubing and mask/cannula may be changed weekly and as needed when in use and nebulizer tubing and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy, the facility failed to ensure proper food storage, labeling, and staff hygiene in the kitchen. This had the potential to affect 93 out of 99 residents residing in the facility, with six residents on nothing by mouth (NPO) diets. The facility census was 99. Findings include: Observation on 09/15/25 from 8:28 A.M. to 8:46 A.M. revealed that in the freezer there was open frozen corn on the cob that was undated, and opened frozen carrots that were undated. In the refrigerator, there was an open strawberry yogurt that was undated, open shredded lettuce that was undated, open shredded cheese that was undated, and open shredded mozzarella cheese with an open date of 08/05/25. In the dry storage area, there was opened spaghetti with an unreadable open date and opened orzo that was undated. Additionally, Dietary Personnel #550 and Dietary Personnel #521 were observed to have hats on with exposed hair coming out of the hat from a ponytail that was not contained in the hat or a hair net. Interview on 09/15/25 at 8:46 A.M. with Dietary Manager #599 confirmed the above findings and stated that she instructed all staff to place hair nets on if there was any exposed hair coming outside of the hats being worn. Review of the facility policy titled, Dating and Labeling, stated that all refrigerated, ready-to-eat, time/temperature controlled for safety (TCS) food held refrigerated for more than 24 hours must be date marked, and unmarked or expired foods must be discarded. Additionally, it stated that food must be clearly marked to indicate the date by which the food will be consumed, served, sold, or discarded, with a maximum of 7 days.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, medical record review, and staff interview, the facility failed to ensure the call light was positioned within reach of one resident. This affected one (Resident #60) of one resident observed for call light placement. The facility census was 99. Findings include: Review of the medical record for Resident #60 revealed an admission date of 09/04/24. Diagnoses included but not limited to sepsis, atrial fibrillation, paranoid schizophrenia, muscle weakness, need for assistance with personal care, dysphagia, mild cognitive impairment, depression, hypothyroidism, hyperlipidemia, acute respiratory failure, retention of urine, signs and symptoms concerning food and fluid intake, neuromuscular dysfunction of bladder, primary hypertension, abnormalities of gait and mobility. Review of the most recent Minimum Data Set (MDS) assessment, dated 09/03/25, revealed the Resident #60 had moderate cognitive impairment. The resident was assessed to require assistance on staff for all his activities of daily living (ADL). In addition, the resident was identified as having a foley catheter and occasional incontinence of the bowel. Review of Resident #60's plan of care, dated 09/04/24, revealed Resident #60 had a risk for falls. Interventions included ensure call light is within reach. Observation on 09/15/25 at 11:30 A.M. revealed Resident #60 in bed on his right side and the call light was lying on the floor behind his bed. Interview with Registered Nurse (RN) #582 on 09/15/25 at 1:39 P.M. confirmed Resident #60's call light was on the floor behind the resident's bed and not within reach of the resident. Observation on 09/22/25 at 8:43 A.M. revealed Resident #60's call light was on the floor behind the bed and not within easy reach of the resident. Interview on 09/22/25 at 1:08 P.M. with RN Regional Clinical Nurse Manager #700 stated there is no call light policy.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on record review and interview the facility failed to ensure resident preferences were followed for medication administration. This affected one (Resident #103) out of one resident reviewed for choices. The facility census was 99. Findings include: Review of the medical record for Resident #103 revealed an admission date of 06/19/25 with diagnoses of cerebral infarction, Parkinson's disease, progressive supranuclear ophthalmoplegia, vitamin d deficiency, falls and hypertension. Review of physician order dated 06/20/25 revealed aspirin 81 milligram (mg) chewable oral tablet, given once daily by mouth for preventative, amlodipine besylate 5 mg oral tablet, given once daily for hypertension, magnesium oxide 400 mg oral tablet, given once daily for cramps and spasms, vitamin D3 125 micrograms (mcg) oral capsule, given once daily as a supplement, and propranolol 10 mg oral tablet every eight hours for hypertension. Review of care plan dated 07/01/25 revealed Resident #103 may require assistance with activities of daily living (ADL) interventions include requires assistance with eating, encouraging activity during daily care and participation in performing ADL's. Review of Minimum Data Set (MDS) 3.0 assessment completed 07/02/25 revealed Resident #103 is moderately cognitively impaired. Review of the Medication Administration Record (MAR) from 09/01/25 through 09/22/25 revealed that the following medications were administered daily at 5:00 A.M. as scheduled: aspirin 81 mg, amlodipine besylate 5 mg oral tablet, magnesium oxide 400 mg and vitamin D3 125 mcg. Additionally, propranolol 10 mg tablet given at 6:00 A.M. Interview on 09/16/25 at 7:30 A.M. with the Director of Nursing (DON) and Regional Clinical Nurse #700 confirmed medication times on some units start at 5:00 A.M. and some units 6:00 A.M. Those times are for the medications that need to be given before meals like Synthroid or omeprazole, or if that is the resident's choice. Otherwise residents are not woken for medications that early. Review of blood pressure summary from 09/10/25 through 09/22/25 revealed the resident was woken up on 09/01/25 at 5:10 A.M., on 09/02/25 at 5:02 A.M., on 09/03/25 at 5:07 A.M., on 09/04/25 at 4:44 A.M., on 09/05/25 at 4:52 A.M., on 09/06/25 at 6:24 A.M., on 09/07/25 at 6:13 A.M., on 09/08/25 at 6:12 A.M., on 09/09/25 at 4:56 A.M., 09/10/25 at 4:50 A.M., on 09/11/25 at 6:08 A.M., on 09/12/25 at 5:13 A.M., on 09/13/25 at 2:08 A.M., on 09/14/25 4:33 A.M., on 09/15/25 at 4:38 A.M., 09/17/25 at 6:36 A.M. , 09/18/25 at 4:16 A.M., 09/20/25 at 4:52 A.M., 09/21/25 at 4:48 A.M. and 09/22/25 at 4:43 A.M. Interview on 09/16/25 at 8:22 A.M. with Resident #103 revealed resident complaint that he gets his morning medication daily between 5:00 A.M. and 6:00 A.M , the resident denied any medications which require being taken before or after meal or without other medications. Resident #103 has asked night shift nursing staff why he is getting the medications early, however they just proceed to hand him his medication and do not provide explanation or rationale. Interview on 09/16/25 at 12:06 P.M. with Registered nurse (RN) #507 confirmed some residents are administered medications in the morning due to staffing, and it lessens the burden on day shift since the resident to nurse ratio is high. RN #507 is unaware of Resident #103 complaints of getting his medication in the early morning but would understand why a resident would be unhappy getting woken up early in the morning, and if a resident is to complaint about their medication timing it would be addressed with unit manager or the Director of Nursing. Interview on 09/17/25 at 1:45 P.M. with Resident #103 resident complaint of staff waking him up at 6:00 A.M. for his medication this morning, he claims he likes to sleep in and would prefer to receive his medications after or around breakfast. Interview on 09/17/25 at 11:23 A.M. with Licensed Practical Nurse (LPN) #575 is unaware of any resident complaints of getting medications early in the morning, but would understand if a resident voiced frustration over being woken up during the middle of their sleep to give medication. LPN #575 denied nursing assessment capturing resident preferences pertaining to what time they would prefer medications or when they would like to wake up.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and staff interview, the facility failed to ensure the signed advanced directive for Resident #4 was correct. This affected one (Resident #4) out of three residents reviewed for advanced directives. The facility census was 99. Findings include: Review of the medical record for Resident #4 revealed an admission date of 12/13/23 with diagnoses that included unspecified diastolic (congestive) heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic obstructive pulmonary disease unspecified, and unspecified sequelae of cerebral infarction. Review of the significant change Minimum Data Set (MDS) 3.0 assessment for Resident #4 revealed a Brief Interview for Mental Status (BIMS) score of 06 out of 15, indicating impaired cognition. Review of the advanced directive for Resident #4 in the medical record revealed it was dated 12/18/23 for Do Not Resuscitate Comfort Care-Arrest (DNRCC-A) and Do Not Intubate (DNI). In the electronic medical record, the advanced directive was listed as DNRCC, and the orders were for DNRCC. Interview on 09/15/25 at 2:57 P.M. with Licensed Practical Nurse (LPN) #549 revealed Resident #4 had transitioned to hospice on 09/06/25. She confirmed that the signed document in the hard medical record chart was for DNRCC-A, but the order stated DNRCC. LPN #549 could not recall which was the active code and stated she assumed it would be updated but did not know where to find the correct code. Review of the medical record chart on 09/17/25 at 11:58 A.M. for Resident #4 revealed that, after surveyor intervention, a newly signed advanced directive was placed in the hard chart for DNRCC, which now matched the physician orders. Interview on 09/17/25 at 11:58 A.M. with LPN #593 confirmed that the newly signed advanced directive was in the hard chart, but it was not dated by the physician.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview ,record review and facility policy, the facility failed to have appropriate diagnosis to support the use of antipsychotic medication for residents and failed to complete labs per pharmacy recommendations and per physician orders. This affected three (Resident #11, Resident #13, and Resident #14) out of five residents reviewed for unnecessary medications. The facility census was 99. Findings include:1.Review of the medical record for Resident #11 revealed an admission date of 03/30/23 with diagnoses of chronic respiratory failure with hypoxia, unspecified psychosis not due to a substance or know physiological condition, insomnia, anxiety and major depressive disorder.Review of care plan dated 03/30/23 revealed resident is at risk for adverse effects related to psychoactive medication use: antipsychotic for psychotic disorder unspecified. Interventions include assess behaviors for which drugs are being given, assess for adverse effects, assess for non-drug approaches to deal with behaviors, give medications as ordered, pharmacy monthly drug review, psychiatric evaluation as needed and reduction in medications when indicated. Review of Quarterly Minimum Data Set (MDS) 3.0 assessment completed 12/27/24 revealed Resident #11 is cognitively intact, has diagnoses of anxiety and depression and is taking antipsychotics. Review of physician order dated 12/31/24 through 02/23/25 revealed perphenazine (antipsychotic) oral tablet four milligrams (mg) by mouth two times a day related to unspecified psychosis not due to a known physiological condition and order type of antipsychotic. Review of physician order dated 02/23/25 through 03/04/25 revealed perphenazine oral tablet four mg by mouth two times a day for major depressive disorder and order type of anti-anxiety. Review of physician order dated 03/11/25 through 06/24/25 revealed perphenazine oral tablet four mg by mouth two times a day related to unspecified psychosis not due to a substance or known physiological concern and order type of standard medication. Review of physician order dated 06/24/25 through 08/15/25 revealed perphenazine oral tablet give two mg give two times a day related to unspecified psychosis not due to a substance or known physiological condition and order type of standard medication. Review of physician order dated 08/15/25 through 08/19/25 revealed perphenazine oral tablet give two mg give two times a day related to unspecified psychosis not due to a substance or known physiological condition and order type of standard medication. Review of physician order dated 08/19/25 through 08/26/25 revealed perphenazine oral tablet give two mg one one time a day for severe nausea and vomiting for seven days and order type of standard medication.Interview conducted on 09/22/25 at 1:01 P.M. with the Director of Nursing confirmed diagnoses of major depressive disorder with auditory hallucinations and unspecified psychosis not due to a substance or known physiological condition were not appropriate diagnoses for usage of perphenazine. The Director of Nursing confirmed the resident does not have a diagnosis of schizophrenia, and the physician order 08/19/25 through 08/26/25 was the only appropriate administration of the medication.Review of Food and Drug Administration label for perphenazine undated revealed indication for medication treatment includes diagnoses of treatment of schizophrenia and for the control of severe nausea and vomiting in adults. Review of unnecessary drugs policy dated 06/27/15 revealed unnecessary drugs are any drug when used in excessive dose; for excessive duration; without adequate monitoring; without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. 2. Review of the medical record for Resident #13 revealed an admission date of 02/18/18 with diagnoses of cerebral atherosclerosis, chronic obstructive pulmonary disease, chronic pain, major depressive disorder, epilepsy, hypertension, schizoaffective disorder bipolar type, dementia, anxiety, anemia, shortness of breath and insomnia. Review of Resident #13 care plan dated 02/21/18 revealed resident is at risk for complications related to diagnosis of seizure disorder interventions include administer medications as ordered. Review of physician order dated 05/21/23 revealed clonazepam (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(klonopin) 0.125 milligrams give one tablet sublingually for involuntary movements and diagnosis of dementia with behaviors. Review of Quarterly minimum data set (MDS) 3.0 assessment completed 06/27/25 revealed Resident #13 has a memory problem, is severely impaired with making decision regarding tasks of daily life, exhibits inattention, disorganized thinking, has delusions and hallucinations, has physician/verbal behaviors 1-3 days of week. Resident #13 also receives antidepressant, antipsychotic and anticonvulsant. Review of monthly pharmacist medication regimen review dated 05/28/25 revealed clonazepam 0.125 mg three times per day was being evaluated, the resident is noted to have been taking the medication since 2023 where it was last increased. Resident has diagnosis of schizoaffective disorder, bipolar, depression, associated agitation/behaviors, and insomnia for which she is seen by psychiatric services. Behaviors include kicking, pacing, yelling, cursing, pinching, expressing false beliefs and seeing/hearing things. Resident is due to gradual dose reduction, with physician contraindication of reduction causes target symptoms to return and/or worsen. with physician response as other. Review of psychiatric progress note dated 06/16/25 revealed patient occasionally screams and yells without any apparent reason, with a plan to continue Zoloft (Selective Serotonin Reuptake Inhibitor for depression) 75 mg daily, Lamictal (Anticonvulsant) 100 mg twice daily, Klonopin (Sedative) 0.125 mg daily, Zyprexa (Antipsychotic) 2.5 mg two times daily and trazodone (Antidepressant and Sedative) 75 mg three times daily. Review of psychiatric progress note dated 07/21/25 revealed staff reported resident is doing well, and is being seen for medication management. Plan for medication management to include Zoloft 75 mg daily, Zyprexa 2.5 mg two times daily and trazodone 150 mg three times daily. Review of physician order dated 09/19/25 revealed clonazepam tablet disintegrating 0.125 mg tablet related to epilepsy, unspecified, not intractable, without status epilepticus. Interview conducted on 09/22/25 at 10:10 A.M. with the Director of Nursing confirmed clonazepam was removed from the residents plan during the psychiatric visit on 07/21/25, however the medication continued to be given for diagnosis of involuntary movements and diagnosis dementia with behaviors. However the resident was seen by the facility physician on 09/19/25 where the diagnosis for the medication indication was changed to epilepsy, unspecified, not intractable, without status epilepticus. Review of Food and Drug Administration label for klonopin tablet revealed indication for usage include seizure disorders and panic disorder. 3. Review of the medical record for Resident #14 revealed an admission date of 03/08/24 with diagnoses of anxiety, insomnia, bipolar disorder and depression. Review of care plan dated 03/14/24 revealed Resident #14 experiences alteration in mood and/or behavior interventions include medications as ordered by physician. Review of admission minimum data set (MDS) 3.0 assessment completed 03/22/24 revealed Resident #14 is cognitively intact, has diagnosis of bipolar, exhibits no behaviors or mood concerns. Review of physician order dated 03/08/24 through 07/02/24 revealed lithium carbonate oral capsule 150 milligrams (mg) by mouth for bipolar disorder. Review of physician order dated 07/03/24 through 07/10/25 revealed lithium carbonate extended release oral capsule 300 milligrams (mg) by mouth for bipolar disorder. Review of laboratory results dated [DATE] revealed lithium level obtain with a value of 0.3 mmol/L. Review of physician order revealed obtain lithium level on 02/05/25 one time only for treatment. Review of daily lab draw list dated 02/05/25 revealed Resident #14 was on list lithium level, specimen marked a collected however no site or phlebotomist listed. Review of monthly medication regimen review dated 06/23/25 revealed please consider ordering a lithium level every six months. Review of physician order dated 07/01/25 revealed lithium level every six months. Review of hospital record dated 07/09/25 revealed lithium level obtain with a value of 0.2 mmol/L. Review of physician order dated 07/12/25 revealed lithium carbonate oral capsule 300 mg one capsule by mouth for bipolar. Interview conducted on 09/22/25 at 10:10 A.M. with the Director of Nursing (DON) confirmed Resident #14 lithium levels should have been checked every six months per physician order, the DON confirmed the lithium level requested on 02/05/25 could not be located in the residents medical record and could not confirm it was completed. Additionally the DON confirmed a pharmacy recommendation had been made on 06/23/25, with a follow up physician (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Tuscany Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 Hazelton Etna Road SW Pataskala, OH 43062	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order on 07/01/25 for the facility to obtain a lithium level, however the lithium level was not obtained and was completed 07/09/25 during pre-operative testing at the local hospital. Review of physician order policy dated 07/14/10 revealed physician orders will be accurately transcribed and initiated, in accordance with professional standards of practice. Review of unnecessary drugs policy dated 06/27/15 revealed unnecessary drugs are any drug when used in excessive dose; for excessive duration; without adequate monitoring; without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review the facility failed to ensure Resident #4 and Resident #99 had accurate Minimum Data Set (MDS) assessments. This affected two (Resident #4 and #99) of 34 medical records reviewed. The facility census was 99. Findings include: 1. Review of the medical record for Resident #4 revealed an initial admission date of 12/13/23 with the latest readmission date of 06/22/25 with the diagnoses including but not limited to diabetes mellitus, neuromuscular dysfunction of bladder, hypertension, hyperlipidemia, hypothyroidism, depression, anxiety, congestive heart failure, cerebral infarct, pressure ulcer and chronic obstructive pulmonary disease. Review of the plan of care dated 06/16/25 revealed the resident had an alteration in skin integrity as evidenced by pressure ulcer to left buttocks. Interventions included assess area for size, color, drainage weekly and as needed, assess condition of skin/dressings as needed, assess for pain and provide treatment per physician order, body check weekly and as needed, dietary consult as needed, dietary supplement per order, do not massage bony prominences, elevate heels in bed as tolerated/needed, encourage and assist resident to keep head of bed less than 30 degrees during periods of rest as tolerated, encourage and assist resident to turn and reposition as needed, enhanced barrier precautions, keep linen dry and as wrinkle free as possible, leave depends open when in bed as tolerated, low air loss mattress, notify physician and family of changes as needed, pressure reducing chair cushion as tolerated/needed, provide assistance with ADL and positioning as needed, provide resident/family education on maintaining skin integrity and potential complications as needed, provide skin care as needed and provide treatments as ordered. Review of the resident's Braden scale dated 04/30/25 revealed a score of 18 indicating the resident was at risk for skin breakdown. Review of the progress note dated 06/15/25 at 3:35 P.M. revealed assessing resident's skin and previously identified MASD resolved, but now there is an unstageable (the wound bed cannot be visualized, and hence the pressure ulcer cannot be staged) pressure ulcer present to coccyx. 50% purple and 50% dry brown crust present to wound bed. Review of the resident's weekly pressure skin grid dated 06/15/25 revealed the resident was found to have an unstageable pressure ulcer to the left buttocks measuring 4.0 centimeters (cm) by 4.0 cm. The wound was described as 50% dry brown crust and 50% purple. The facility implemented the intervention to Cleanse wound with normal saline. Pat dry. Apply primary dressing: Triad ointment. Cover with secondary dressing: Bordered adhesive foam dressing. Change every day and as needed. Review of the resident's readmission skin assessment dated [DATE] revealed the resident was readmitted to the facility with a pressure wound to the left buttocks measuring 4.0 cm by 3.5 cm by 0.2 cm. The wound had no staging, description of the wound or if exudate was present. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was at risk for skin breakdown and had one unstable pressure ulcer that was present on admission. The facility implemented the interventions pressure reducing device to bed/chair, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, application of nonsurgical dressing other than to feet and application of ointments/medications other than to feet. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's monthly physician orders for September 2025 identified orders dated 08/17/25 evaluate and assess pressure area with dressing located at left buttocks every shift, 08/24/25 cleanse wound to left buttocks with soap and water, pat dry, apply calcium alginate with silver, cover with bordered adhesive foam dressing every shift and as needed if dressing is soiled or dislodged. On 09/22/25 at 11:20 A.M., interview with the Registered Nurse (RN) #700 verified the resident was readmitted to the facility with the same unstageable pressure ulcer identified on 06/15/25 and the MDS was coded inaccurately to reflect the unstageable pressure ulcer was a newly identified wound. 2. Review of the medical record for Resident #99 revealed an admission date of 06/13/25 with diagnoses including iron deficiency anemia secondary blood loss (chronic), vascular dementia unspecified severity without behavioral disturbance, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, and personal history of transient ischemic attack and cerebral infarction without residual deficits. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. Recorded impairment on one side for upper and lower extremities, setup required for eating, dependent-maximal assistance required for all activities of daily living (ADLs), and no medical equipment was noted. The MDS documented that the resident was not able to ambulate in her wheelchair. Review of the progress note dated 06/19/25 at 10:23 A.M. documented that the resident was alert, sociable, and spending time with family. The note indicated the resident wore glasses, had a wheelchair and walker, and was observed using her wheelchair. The resident engaged in preferred activities including knitting, watching news and westerns, listening to Christian music, and attending church services via iPad. Interview on 09/18/25 at 2:48 P.M. with Resident #99 confirmed she had a wheelchair since admission. Interview on 09/18/25 at 2:58 P.M. with Registered Nurse (RN) #524 confirmed the resident initially had a wheelchair upon admission. During the survey, Resident #99 was observed multiple times in her wheelchair maneuvering throughout the facility, including independently eating in the dining room. Interview on 09/18/25 at 3:03 P.M. with MDS Nurse #515 confirmed the MDS entry indicating the resident did not use a wheelchair was entered in error. Staff had verbally reported the resident did not use a wheelchair, but this was not documented in the chart.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure timely follow-up for Resident #6's level II Preadmission Screening and Resident Review (PASARR) evaluation. This affected one (Resident #6) out of one resident reviewed for PASARRs. The facility census was 99. Findings include: Review of the medical record for Resident #6 revealed an admission date of 08/05/24 with diagnoses that included paraplegia, hereditary and idiopathic neuropathy, injury of urethra, schizoaffective disorder, and post-traumatic stress disorder. Review of the annual Minimum Data Set (MDS) 3.0 assessment for Resident #6 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of the medical record chart for Resident #6 revealed the PASARR indicated the need for a level II evaluation, but there was no documented evaluation or attempt in the medical chart for the level II evaluation. Interview on 09/16/25 at 3:35 P.M. with Social Worker (SW) #583 verified that another staff member, not present, initially submitted the PASARR level II evaluation to the Department of Developmental Disabilities ([NAME]) on 03/07/25 and provided the electronic submission. Interview on 09/17/25 at 2:39 P.M. with SW #583 provided follow-up that they submitted to [NAME] via email, after surveyor intervention, on 09/16/25 stating they had called previously for the evaluation but had not received it. SW #583 could not provide any documented evidence that the call took place. After the email was submitted, [NAME] provided the level II evaluation with a date of determination on 04/02/25 and a mailing date of 04/02/25. SW #583 scanned the level II determination on 09/17/25.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, and staff interview, the facility failed to develop and implement a comprehensive care plan addressing Resident #8's contractures. This affected one (Resident #8) out of nine residents reviewed for activities of daily living. The facility census was 99. Findings include: Review of the medical record chart for Resident #8 revealed an admission date of 01/22/22 with diagnoses that included type II diabetes, dementia, psychotic disturbance, mood disturbance, anxiety, secondary parkinsonism, stiffness of unspecified joint, and schizoaffective disorder. Review of the 5-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 09 out of 15, indicating impaired cognition. The assessment documented that the resident had impairments in both upper extremities and was maximally dependent for upper extremity dressing. The resident was also dependent on staff for rolling left and right in bed and required assistance with transfers. Observation on 09/15/25 at 11:26 A.M. of Resident #8 revealed her wrists were contracted with her fingers folded into her palm. Review of the care plan for Resident #8 revealed the only mention of her wrists concerned noncompliance with orthotic orders. There was no documentation addressing the resident's contracture wrists or interventions to maintain range of motion. There were no measurable goals, specific interventions, or monitoring instructions for range-of-motion exercises, hand positioning, or hygiene. The care plan was not updated after occupational therapy discontinued services on 04/10/24, despite ongoing documentation of contractures in progress notes. Staff interviews confirmed they provided care or therapy but did not reference adding this to the care plan. Review of progress notes revealed that on 04/10/24 at 09:52 A.M., a therapy note documented that the resident refused to wear bilateral hand orthotics, and occupational therapy services were discontinued. On 06/20/25 during a chronic visit with the provider note it detailed the resident had bilateral upper-extremity hand contractures and tremors, and bilateral hand splints applied were documented. On 07/08/25 during a readmission visit, bilateral upper-extremity hand contractures and tremors were again documented with splints applied and skin intact. Post-acute care visits on 07/15/25, 07/18/25, and 07/22/25 continued to document bilateral upper-extremity hand contractures and use of splints, with no additional interventions recorded in the care plan. On 07/29/25 during a post-acute care visit, the right hand was noted as more contracted than the left, with a splint in place and recommendations included supportive care and continued use of splints. Chronic visits on 08/05/25 and 08/22/25 documented upper-extremity hand contractures (right greater than left) and use of splints; no care plan orders or interventions regarding the wrists were present beyond splint application with no observation of splints being used by the resident. Interview on 09/17/25 at 10:54 A.M. with Resident #8 revealed she did not have splints in place and could not recall if splints had ever been used or if therapy would help. Interview on 09/17/25 at 10:59 A.M. with Licensed Practical Nurse (LPN) #593, revealed staff previously attempted to place splints, but the resident removed them. She could not confirm if splints were currently available in the resident's room. Interview on 09/18/25 at 8:54 A.M. with Registered Nurse (RN) #524, revealed the last orders for the resident's palms were in April 2024 due to refusal of the palm guards, and there was no information in the care plan regarding her contractures.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and resident interview, the facility failed to provide appropriate Activities of daily living (ADL) care for resident's dependent on staff. This affected two (Residents #8 and #70) out of 9 residents reviewed for ADLs. The facility census was 99. Findings include: 1. Review of the medical record for Resident #8 revealed an admission date of 01/10/22 with diagnoses including urinary tract infection, chronic obstructive pulmonary disease, type 2 diabetes mellitus without complications, and morbid (severe) obesity due to excess calories. Review of the 5-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 09 out of 15, indicating impaired cognition. The assessment documented that the resident had impairments on both upper extremities, was dependent on staff for personal care tasks including eating, oral hygiene, toileting, bathing, and dressing, and was dependent for rolling and transfers. Review of the care plan revealed noncompliance with orthotic orders and personal care; however, no care plan interventions addressed the resident's contracture wrists or hygiene needs. Observation on 09/18/25 at 08:56 A.M. revealed the resident's wrists were contracted with fingers folded into the palms. The right palm had redness and fingers were painful when pulled back. The right palm had a foul odor, white residue, redness, and hair removed from the palm. The resident's fingernails on the right hand were approximately half an inch long. Observation confirmed by Registered Nurse (RN) #524. Additionally, observation on 09/18/25 at 11:10 A.M. confirmed that the right fingernail was long, and hair had been removed from the right palm during observation, which was confirmed by Regional Clinical Nurse #700. Review of shower records indicated the resident received a bath the morning of 09/18/25 at 12:26 A.M. and nails were trimmed but the observation showed the fingernail was long in length. Observation on 09/18/25 at 11:10 A.M. revealed hair had been removed from the fingers. The right fingernail was about one-half inch long. The resident stated she liked her fingernails short and requested they be trimmed, and Misty began trimming the nail. The resident stated no one had cleaned her palm after the morning observation. Regional Staff reported that RN #524 changed her statement when they spoke with her and said she did not think the hand was red or had an odor. The surveyor asked regional Nurse #700 to smell the resident's hand but she declined. Regional Nurse #700 stated staff would not document if a resident's hands were cleaned and that refusals should be documented in the chart, but no refusals were noted other than the therapy recommendations. Interview on 09/18/25 at 11:10 A.M. with Resident #8 confirmed that she preferred to have her fingernails short in length and stated she would like to have them cut. 2. Review of the medical record for Resident #70, revealed an admission date of 05/19/23 and re-entry date of 03/03/25. Diagnoses included but were not limited to epilepsy, morbid obesity, mild intellectual disabilities, shortness of breath, pulmonary embolism without acute cor pulmonale (a blood clot in the lung which does not cause sudden, acute heart strain on the right side of the heart), primary hypertension, vitamin D deficiency, traumatic brain injury, dyspnea, chronic pain syndrome. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15. The resident was assessed to be dependent on staff for personal hygiene which included combing hair and shaving. Resident #70 was assessed to require maximum assistance in showering or bathing. Observation on 09/16/2025 at 08:20 A.M. revealed Resident #70 was lying in her bed wearing a t-shirt which had crusted food near the neckline seam of the t-shirt. Resident #70 had worn the t-shirt all day yesterday 09/15/25. Additionally, Resident #70 had several days of black and white colored, bristly, hair growth on chin and upper lip. Interview on 09/16/25 at 08:20 A.M. Resident #70 stated she does not like the hair growing on her chin and upper lip. Resident #70 stated she only gets shaved when she gets her showers. Resident #70 also stated she was not offered a gown or pajamas to sleep in the previous night, so she was still in her t-shirt from the prior day. Interview on 09/16/2025 at 8:28 A.M. with Certified Nursing Assistant (CNA) #573 confirmed Resident #70's t-shirt had dried crusted food on it from the previous day. CNA #573 verified Resident #70 had facial hair and stated it looked like the facial hair growth was three to four days old. CNA #573 confirmed Resident #70 is totally dependent on staff for personal hygiene. Review of shower sheets revealed Resident #70 had a shower on 09/14/25. Requested personal care policy and activities of daily living (ADL) policy and Registered Nurse #700 stated there are no facility policies for personal care or ADLs.		

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F 0684 Level of Harm - Minimal harm or potential for 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, hospice record review and interview, the facility failed to ensure hospice information, including the hospice certification and plan of care for certification was up to date and available at the facility. This affected one resident (#44) of one resident reviewed for hospice services. The facility census was 99. Findings Include: Review of the medical record for Resident #44 revealed an initial admission date of [DATE] with the diagnoses including but not limited to chronic obstructive pulmonary disease, pulmonary embolism, congestive heart failure, hypertension, chronic kidney disease, hyperlipidemia, gastro-esophageal reflux disease, osteoarthritis, constipation, hypothyroidism, anxiety disorder and chronic respiratory failure. Review of the plan of care dated [DATE] revealed the resident received hospice services for end stage chronic respiratory failure with hypoxia. Interventions included follow physician's orders and Resident's advanced directives, hospice services as ordered, hospice to collaborate care with facility staff, contact hospice for changes in resident condition, assist with grieving process by allowing resident to express concerns/fears offer supportive but realistic feedback, provide emotional support and comfort measures, oral hygiene frequently, skin inspection during care, medications as ordered, pain assessment as needed, monitor resident for breakthrough pain, provide pain control and pain medications as ordered. Review of the resident's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident received hospice services. Review of the resident's monthly physician orders for [DATE] identified orders dated [DATE] to admit to hospice services. Review of the plan of care located in the binder indicated the hospice recertification and plan of care expired on [DATE]. Further review revealed the hospice certification and plan of care was good through [DATE] to [DATE]. Review of the resident's hospice certification and plan of care for certification period [DATE] to [DATE] revealed on [DATE] a verbal order was obtained for recertification on [DATE] with a terminal diagnosis of chronic respiratory failure with hypoxia with a life expectancy of six months or less if the disease runs its normal progression from Hospice Physician (HP) #705 by Hospice Registered Nurse (HRN) #710. Further review revealed the HP #705 signed the hospice recertification and plan of care on [DATE] when the certification was requested by the surveyor. On [DATE] at 2:50 P.M., an interview with Registered Nurse #700 revealed the resident's hospice service was in the building and reviewed the resident's information and verified the information was up to date. The RN verified the hospice company sent the resident's hospice certification and plan of care on [DATE] after being requested by the surveyor and following the physician's signature. Review of the hospice contract [DATE] revealed hospice shall obtain a written certification of terminal illness for each hospice patient's election period specifying that the hospice patient has a medical prognosis that his or her life expectancy is six months or less is the terminal illness runs its normal course and including specific clinical findings and other documentation supporting a life expectancy of six months or less. The written certification shall be signed and dated by the hospice Medical Director or a physician member of the hospice interdisciplinary group. The hospice shall (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtain the written certification no later than two calendar days after hospice patient begins to receive care from hospice and no later than two calendar days after hospice care is initiated in any subsequent benefit period.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and facility policy review, the facility failed to comprehensively assess pressure ulcers/injury upon admission/readmission to the facility. This affected two residents (#2 and #4) of seven residents reviewed for pressure ulcers. The facility census was 99. Findings include: 1. Review of the medical record for Resident #2 revealed an initial admission date of 02/02/24 with the latest readmission date of 06/30/25 with the diagnoses including but not limited to acute myocardial infarction, acute respiratory failure with hypoxia, diabetes mellitus, dysphagia, atrial fibrillation, congestive heart failure, anxiety disorder, depression, sleep apnea, pressure ulcer, sick sinus syndrome, obstructive and reflux uropathy and gastrostomy status. Review of the plan care dated 04/15/25 revealed the resident had an alteration in skin integrity as evidenced by a pressure ulcer to the coccyx. Interventions included assess area for size, color, drainage weekly and as needed, assess condition of skin/dressing as needed, assess for pain and provide treatment per physician order, body check weekly and as needed, dietary supplement per order, dietary consult as needed, do not massage bony prominences, encourage and assist resident to elevate heels when in bed needed/tolerated, encourage and assist resident to turn and reposition as needed, enhanced barrier precautions, keep linen dry and as wrinkle free as possible, maintain pressure reducing mattress, notify the physician and family of changes as needed, pressure reducing chair cushion as tolerated/needed, provide assistance with activities of daily living (ADL) and positioning as needed, provide resident/family education on maintaining skin integrity and potential complications as needed, provide skin care as needed and provide treatments per physician orders. Review of the resident's readmission skin assessment dated [DATE] revealed the resident was readmitted to the facility with a stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) pressure ulcer to her coccyx measuring 4.5 centimeters (cm) by 1.5 cm by 0.3 cm. The assessment had no description of the wound or presence of exudate. The facility implemented the treatment to cleanse the area and apply triad paste to affected area. Review of the resident's weekly pressure skin grids revealed the pressure ulcer was assessed weekly on the following dates, 04/20/25, 04/27/25, 05/04/25, 05/11/25, 05/18/25, 05/25/25, 06/01/25 and 06/08/25. Review of the resident's readmission skin assessment dated [DATE] revealed the resident was readmitted to the facility with a stage III pressure ulcer measuring 8.1 cm by 2.4 cm by 0.3 cm. The assessment had no description of the wound or presence of exudate. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive impairment. The assessment indicated the resident was at risk for skin breakdown and had one stage III pressure ulcer present on admission. The resident was also coded as having MASD. The facility implemented the interventions pressure reducing device to bed/chair, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, application of nonsurgical dressing other than to feet and application of ointments/medications other than to feet. Review of the resident's weekly pressure skin grids revealed the pressure ulcer was assessed weekly on the following dates, 07/06/25, 07/13/25, 07/20/25, 07/27/25, 08/03/25, 08/10/25, 08/17/25, 08/24/25, 08/31/25 and 09/07/25. Review of the most recent weekly pressure skin grid dated 09/14/25 revealed the resident's stage III pressure ulcer to the coccyx measured 0.5 cm by 0.3 cm by 0.1 cm and described as 100% red granulation tissue with the peri wound have moisture associated skin damage. The facility had determined the wound had improved and continued the treatment of cleans wound with normal saline, pat dry and apply triad ointment every shift and as needed. Review of the resident's monthly physician orders for September 2025 identified orders dated 08/03/25 cleanse wound to coccyx with normal saline, pat dry, apply triad ointment, cover with bordered adhesive foam dressing daily and as needed for soiled or dislodged, 08/31/25 evaluate and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Tuscany Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 Hazelton Etna Road SW Pataskala, OH 43062	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assess pressure area without a dressing every shift and cleanse fungal dermatitis/MASD to left buttocks with soap and water, pat dry, then apply triad ointment every shift. On 09/22/25 at 11:20 A.M., an interview with the Registered Nurse (RN) #700 revealed the nurse staged the wound the same as prior to her hospitalization as a stage III pressure ulcer and the assessment contains a description of what a stage III pressure ulcer would look like at the top of the assessment. The RN verified the resident had no comprehensive assessment completed upon readmission to the facility of the stage III pressure ulcer. 2. Review of the medical record for Resident #4 revealed an initial admission date of 12/13/23 with the latest readmission date of 06/22/25 with the diagnoses including but not limited to diabetes mellitus, neuromuscular dysfunction of bladder, hypertension, hyperlipidemia, hypothyroidism, depression, anxiety, congestive heart failure, cerebral infarct, pressure ulcer and chronic obstructive pulmonary disease. Review of the plan of care dated 06/16/25 revealed the resident had an alteration in skin integrity as evidenced by pressure ulcer to left buttocks. Interventions included assess area for size, color, drainage weekly and as needed, assess condition of skin/dressings as needed, assess for pain and provide treatment per physician order, body check weekly and as needed, dietary consult as needed, dietary supplement per order, do not massage bony prominences, elevate heels in bed as tolerated/needed, encourage and assist resident to keep head of bed less than 30 degrees during periods of rest as tolerated, encourage and assist resident to turn and reposition as needed, enhanced barrier precautions, keep linen dry and as wrinkle free as possible, leave depends open when in bed as tolerated, low air loss mattress, notify physician and family of changes as needed, pressure reducing chair cushion as tolerated/needed, provide assistance with ADL and positioning as needed, provide resident/family education on maintaining skin integrity and potential complications as needed, provide skin care as needed and provide treatments as ordered. Review of the progress note dated 06/15/25 at 3:35 P.M. revealed while assessing the resident's skin, the previously identified moisture associated skin damage (MASD) resolved, however there was an unstageable pressure ulcer present to the coccyx described as 50% purple and 50% dry brown crust present to wound bed. Review of the resident's weekly pressure skin grid dated 06/15/25 revealed the resident was found to have an unstageable pressure ulcer to the left buttocks measuring 4.0 centimeters (cm) by 4.0 cm. The wound was described as 50% dry brown crust and 50% purple. The wound was assessed by the Certified Nurse Practitioner (CNP) and an autolytic debridement was completed. The facility implemented the intervention to cleanse wound with normal saline, pat dry, apply Triad ointment and cover with a bordered adhesive foam dressing daily and as needed. Review of the resident's readmission skin assessment dated [DATE] revealed the resident was readmitted to the facility with a pressure wound to the left buttocks measuring 4.0 cm by 3.5 cm by 0.2 cm. The wound had no staging, description of the wound or if exudate was present. Review of the resident's weekly pressure skin grid dated 06/29/25 revealed the wound to the left buttocks was now classified as a stage III pressure ulcer measuring 4.0 cm by 3.5 cm by 0.2 cm and described as being 100% red. The facility determined the wound had improved. The facility changed the treatment cleanse wound with normal saline. Pat dry. Apply primary dressing: Triad ointment. Cover with secondary dressing: Bordered adhesive foam dressing. Change every day and as needed. Review of the resident's weekly pressure skin grids dated 07/06/25, 07/13/25, 07/20/25, 07/27/25, 08/03/25, 08/10/25, 08/17/25, 08/24/25, 08/31/25, 09/07/25 were assessed weekly by the CNP. Review of the resident's latest weekly pressure skin grid dated 09/14/25 revealed the stage III pressure ulcer to the left buttocks remained classified as an unstageable and measured 1.5 cm by 1.8 cm and described as 70% yellow and 30% red with a moderate amount of serosanguineous drainage. The facility determined the wound had improved and continued the current treatment. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was at risk for skin breakdown and had one unstable pressure ulcer that was present on admission. The facility implemented the interventions pressure reducing device to bed/chair, nutrition or hydration intervention to manage (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin problems, pressure ulcer/injury care, application of nonsurgical dressing other than to feet and application of ointments/medications other than to feet. Review of the resident's monthly physician orders for September 2025 identified orders dated 08/17/25 evaluate and assess pressure area with dressing located at left buttocks every shift, 08/24/25 cleanse wound to left buttocks with soap and water, pat dry, apply calcium alginate with silver, cover with bordered adhesive foam dressing every shift and as needed if dressing is soiled or dislodged. On 09/17/2025 at 3:20 P.M., an interview with RN #700 revealed the wound was previously MASD that evolved into a pressure ulcer. She said the resident had a decline, poor intake and was now receiving hospice services. RN #700 verified the lack of a comprehensive assessment to the stage III pressure ulcer. 09/22/25 at 11:20 A.M., interview with the Regional Nurse revealed the nurse staged the wound as a stage III pressure ulcer and the assessment contains a description of what a stage III pressure ulcer would look like at the top of the assessment. The RN verified the resident had no comprehensive assessment completed upon readmission. Review of the facility policy titled, Skin Assessment, last revised 03/15/24 revealed it was the intent of the facility to provide necessary care to prevent the development of pressure injuries unless the resident's clinical condition demonstrates that the development is unavoidable. Areas of altered skin integrity that are present or which develop subsequently to admission are treated according to medical direction and are conscientiously followed. An assessment of a resident's alteration in skin integrity shall be performed and recorded in the resident's medical record at least weekly. Staging of a pressure injury is performed to indicate the characteristics and extent of tissue injury. Licensed nurses may perform a comparative analysis of the pressure injury to a staging chart and document the observation, measurements and comparative analysis, including the stage of the wound.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, the facility failed to monitor and provide timely follow-up for Resident #8's bilateral wrist contractures. This affected one (Resident #8) out of two residents reviewed for mobility and range of motion. The facility census was 99. Findings include: Review of the medical record for Resident #8 revealed an admission date of 01/10/22 with diagnoses including type 2 diabetes mellitus without complications, dementia, psychotic disturbance, mood disturbance, anxiety, secondary parkinsonism, stiffness of joint, and schizoaffective disorder. Review of the 5-day Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 09 out of 15, reflecting impaired cognition. The MDS documented dependency on staff for personal care including eating, oral hygiene, toileting, bathing, and dressing, and full or partial dependence for transfers, rolling, and mobility. The resident's care plan did not address management of bilateral wrist contractures or the use of hand orthotics. There were no measurable goals, specific interventions, or monitoring instructions for range-of-motion exercises, hand positioning, or hygiene. The care plan was not updated after occupational therapy discontinued services on 04/10/24, despite ongoing documentation of contractures in progress notes. Review of therapy documentation showed that Occupational Therapy (OT) services were discontinued on 04/10/24 after the resident refused to wear bilateral hand orthotics. The note, dated 04/10/24 at 09:52 A.M., stated, Resident refused to wear bilateral hand orthotics; therefore, OT services discontinued. Voice mail left for Power of Attorney regarding discharge of OT services. Progress notes between April 2024 and June 2025 consistently documented the presence of upper extremity contractures and hand splints during routine provider visits but contained no evidence of active therapy or follow-up. For example, 06/20/25 at 02:35 P.M., Chronic Visit by the Advanced Practice Registered Nurse-Certified Nurse Practitioner (APRN-CNP): upper-extremity hand contractures/tremors; bilateral hand splints applied. Additionally, 07/08/25 at 11:12 A.M., readmission by, APRN-CNP: upper-extremity hand contractures/tremors; bilateral hand splints applied. Interview on 09/17/25 at 10:54 A.M. with Resident #8 revealed no splints were in place. The resident stated she did not think she had splints in the past, could not answer if she thought splints would help, and became non-responsive. Interview on 09/17/25 at 10:59 A.M. with Licensed Practical Nurse (LPN) #593, revealed splints had previously been attempted but she could not recall how long it had been since their last use. She stated therapy had met with the resident initially, but the resident removed the splints when they were placed. She was not sure if there were any splints currently in the resident's room. Interview on 09/17/25 at 04:15 P.M. with Rehabilitation Director #800, revealed a referral for contractures occurred on 06/11/25 and again on 07/07/25. He stated the equipment included bilateral palm guards, which are used only to prevent fingers from digging into palms. He reported that a restorative program existed from January 2023 and that the restorative aide had provided passive range-of-motion services. He stated measurements on 06/11/25 showed left-wrist flexion of 30 degrees and right-wrist flexion of 20 degrees, and on 07/07/25 the left wrist was not measured and the right wrist measured 30 degrees. He added they attempted to bring the resident back for skilled therapy after the July visit, but she only qualified for restorative services. Interview on 09/18/25 at 08:54 A.M. with Registered Nurse (RN) #524, revealed the last orders for palm guards were in April 2024 due to resident refusal and that there was no information in the care plan addressing the resident's contractures. Interview on 09/18/25 at 08:51 A.M. with Restorative Aide #559, revealed she last worked with the resident in 2023, providing range-of-motion services and applying palm guards to the resident's hands. Interview on 09/18/25 at 10:44 A.M. with Regional Rehab director #860, revealed a transitional document from the previous therapy company dated 01/25/25 contained no measurements. She stated that on 03/20/24 it was documented the resident (continued on next page)		

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only tolerated a palm protector and refused to wear the orthosis. She confirmed splint refusals in April 2024 and confirmed the next referral was in June 2025. She added there were no original measurements from prior to January 2023 and that the handoff from the previous occupational therapist contained no measurements so it was unable to be determined if there was a decline in the residents mobility. Interview on 09/18/25 at 10:51 A.M. with Occupational Therapist (OT) #850, revealed the NA (not assessed) entry for the left-wrist measurement on 07/07/25 could have been a documentation error. He stated he attempted to locate the resident's wrist splints in the room but found only foam rollers and no palm guards. Review of the medical chart revealed no evidence of monitoring or additional interventions for Resident #8's contracture wrists from April 2024 to June 2025 including any restorative aide intervention.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, medical record review to include hospital records, progress notes, and urology notes, and facility policy review, the facility failed to properly and safely maintain urinary catheters to include the timely address of urology recommendations for one resident's suprapubic catheter. This affected two residents (#60 and #81) of six residents reviewed for catheter care. The facility census was 99. Findings include: 1. Review of the medical record for Resident #60 revealed an admission date of 09/04/24. Diagnoses included but not limited to sepsis, A-fib, paranoid schizophrenia, muscle weakness, need for assistance with personal care, dysphagia, mild cognitive impairment, depression, hypothyroidism, hyperlipidemia, acute respiratory failure, retention of urine, s/s concerning food and fluid intake, neuromuscular dysfunction of bladder, primary hypertension, abnormalities of gait and mobility. Review of the most recent Minimum Data Set (MDS) assessment, dated 09/03/25, revealed that Resident #60 had a moderate cognitive impairment. The resident was assessed to require assistance from the staff for all his activities of daily living (ADL). In addition, Resident #60 was identified as having a foley catheter and occasional incontinence of the bowel. Review of Resident #60's plan of care, dated 09/04/24, revealed Resident #60 had an alteration in elimination foley catheter for diagnosis of neuromuscular bladder, continent of bowel. Resident #60 had a voiding trial which failed twice with the foley removed on 10/11/24 and the foley placed again on 10/31/24. Resident #60's interventions for the alternation in elimination included enhanced barrier precautions, irrigate foley per order, foley catheter care every shift and as needed (PRN), empty foley catheter bag every shift and prn, secure foley catheter tubing to prevent accidental dislodgement, foley bag in place prn, keep foley catheter bag below the level of the bladder to prevent backflow, determine if removal is possible, monitor of signs and symptoms of a urinary tract infection (UTI) such as elevated temperature, dysuria (pain at urination), flank pain, hematuria, foul smelling urine, report to physician to seek diagnosis and treatment promptly. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) revealed an order with a start date of 11/06/24 and discontinue date of 09/18/25 for a 20 French (FR) indwelling foley catheter with a ten cubic centimeter (cc) balloon to gravity every shift for neurogenic bladder. Resident #60's care plan stated the catheter is a Coude (medical device used for urinary catheterization that features a bent or curved tip to help it navigate past obstructions like an enlarged prostate or urethral strictures, making it easier and less painful for men and women with certain urinary conditions to empty their bladder) catheter. There is no order noted for the Coude catheter and no size for the Coude catheter noted. Further review of the MAR and TAR revealed a current order for acetic acid irrigation solution zero-point twenty-five percent (0.25%) use 30 cc via irrigation every day every shift for foley care with a start date of 01/2/25. Resident #60 has a current order for catheter care every shift every day with a start date of 10/31/24. Additionally, there is a current order to change catheter if signs and symptoms of infection or system leak/compromised as needed with a start date of 09/18/25. Review of hospital records for Resident #60 dated 05/01/25 revealed primary encounter diagnosis as displacement of foley catheter and foley was replaced at the hospital emergency room. Resident #60 was ordered cephalexin (Keflex) 500 milligram (mg) with instructions to take one capsule by mouth four times a day for seven days. Review of hospital records for Resident #60 dated 05/08/25 stated (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the reason for visit was bloated. The diagnosis for Resident #60 on 05/08/25 was malfunction of foley catheter. The hospital records also stated the foley catheter was not in the appropriate place. The balloon had to be deflated, and the catheter had to be inserted more as there wasn't enough fluid in the foley balloon. Review of hospital records dated 08/26/25 stated Resident #60's catheter was replaced in the emergency room and blood-stained urine in the bag which was mostly from a trauma. No hospital records noted for 07/02/25 hospital visit. Review of a progress note dated 07/02/25 revealed the urologist was called and Resident #60 was sent to the emergency room for his catheter to be replaced as his current catheter wasn't flushing. Review of the Urology notes for Resident #60 dated 06/06/25 indicated the chief complaint as follow up urinary retention. Records show placement of a 16 FR two-way Coude catheter using sterile technique during the 06/06/25 visit. The balloon was inflated with ten cc of fluid. There was immediate return of urine. The bladder was irrigated, revealing proper placement of the catheter and clear yellow urine. Resident #60 had specific patient counseling related to significant urethral erosion (occurs when prolonged or improper use of an indwelling urinary catheter causes the urethra to wear away, creating a pressure injury that can range from meatus erosion (at the opening) to erosion of the full urethra or surrounding tissues. Risk factors include poor catheter security, prolonged use, and conditions like diabetes or poor mobility.) Resident #60 was recommended to transition to a suprapubic (a drainage tube placed through a small surgical incision in the lower abdomen to drain urine from the bladder when urination is not possible through the urethra) catheter which is a preventative measure against further urethral erosion. The urologist placed a referral for Resident #60 for interventional radiology for the placement of a suprapubic catheter. Review of a urology record for Resident #60 dated 06/23/25 revealed repeated attempts by the urologist to contact the patient and/or nursing staff at the facility as unsuccessful. Review of the urology record for Resident #60 dated 07/08/25 reported contact was made with the patient and one of the nursing staff. The urologist learned at this time that the patient has a power of attorney (POA). The urologist called the POA and explained the suprapubic procedure to the POA and the POA agreed the procedure was reasonable. Resident #60's POA explained there was an issue with Resident #60's insurance which the facility was working on. The urologist noted the staff were to straighten out the insurance issue and to get back with them. Furthermore, the urologist noted the nursing staff and POA were amendable with the above plan. Review of progress note dated 07/02/25 revealed interventional radiology was to call the unit manager on 07/09/25 to schedule the suprapubic catheter placement. No further notes noted regarding the scheduling of the appointment for the suprapubic procedure. Review of progress notes dated 04/21/25 to 09/17/25 which revealed Resident #60 has a cognitive impairment noted multiple times and multiple notifications made to Resident #60's sister when a change in condition occurred or Resident #60 was sent to the hospital. Observations on 09/15/25 at 11:31 A.M. and 1:26 P.M. revealed Resident #60 has a catheter and the catheter bag is hooked to his walker. Interview on 09/15/25 at 11:26 A.M. with Certified Nursing Assistant (CNA) #637 who stated Resident #60's catheter leaked a lot and didn't collect in the bag until he went to the hospital. CNA #637 reported the leaking around the catheter happened for a couple of months. She reported it to the nurse but stated nothing changed until Resident #60 went to the hospital. CNA #637 stated now Resident #60 has a special catheter which can't be changed at the facility, and they don't have the supplies for (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it. CNA #637 stated Resident #60 would need to go to the hospital for the catheter to be changed. Interview on 09/17/25 at 5:15 P.M. with Licensed Practical Nurse (LPN) #547 stated Resident #60 has had trouble with his catheter because the resident sometimes pulls it out. LPN #547 stated the staff can't put the catheter back in so Resident #60 must go to the hospital to have the catheter replaced if it becomes dislodged. Interview on 09/18/25 at 8:22 A.M. with LPN #534 who stated Resident #60 does have a catheter. LPN #534 stated Resident #60's catheter is a 16Fr 10 milliliter (mL) Coude catheter. LPN #534 stated he is not familiar with a Coude catheter. LPN #534 stated Resident #60 does go to an outside urologist but wasn't sure when the resident had last been seen. Interview on 09/18/2025 at 11:30 A.M. with Regional RN #700 and Director of Nursing (DON) stated the nurses would change the Coude catheter unless Resident #60 is someone who would have to go out to urology. Regional RN #700 stated Resident #60's catheter was flushed before he went to the hospital on [DATE]. Furthermore, Regional RN #700 stated the catheter is not changed unless signs or symptoms of a UTI or system leakage. DON stated she is not sure if the plan is for Resident #60 to get a suprapubic catheter. Interview on 09/22/2025 at 8:17 A.M. Resident #60 stated he doesn't remember how long he has had the catheter. Furthermore, Resident #60 stated he doesn't remember going to the urologist or anyone discussing the suprapubic catheter with him on 09/18/25. Resident #60 stated he thinks he is supposed to go to the hospital if there are issues with his catheter and stated he doesn't pull at his catheter. Interview on 09/22/2025 at 8:43 A.M. interview with RN #631 who acknowledged Resident #60 had an urology appointment earlier in the year and stated she didn't know what happened. RN #631 stated the unit manager, or DON follows up on specialist or doctor's appointments for the residents. RN #631 revealed the unit manager would follow up if a resident needed a procedure or follow up appointment. RN #631 stated she would schedule a procedure if it were needed as she is the unit manager. RN #631 stated Resident #60 is not his own decision maker, that his sister is his decision maker. RN #631 revealed Resident #60's sister would be involved in determining if resident would proceed with the suprapubic procedure. RN #631 stated Resident #60 does have a diagnosis of dementia or cognitive impairment. Interview on 09/22/2025 at 11:00 A.M. with RN #570 confirmed Resident #60's snap secure (device to secure a catheter) is broken and Resident #60's catheter not secured. Furthermore, RN #570 stated Resident #60's catheter could become dislodged from the urethra since the catheter is not secured. Additionally, RN #570 stated if Resident #60 rolls over, the catheter will tug since it is not locked in place. RN #570 stated usually the aides will report that the snap secure is broken, but no one told her today. RN #570 stated Resident #60's sister is his decision maker. RN #570 revealed she calls Resident #60's sister if major things are going on with him or if there is a change in condition. In addition, RN #570 revealed she knows Resident #60 is supposed to have an appointment to get a suprapubic catheter placed but doesn't know when. RN #570 verified the unit manager is the person responsible for making resident appointments and notifying the nurses. Interview on 09/22/2025 at 11:26 A.M. with DON who confirmed the unit managers are the staff who schedule follow up appointments or appointments with specialists after consulting with family representative. (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/22/2025 at 11:30 A.M. requested policy on physician/appointments for follow up or continuity of care policy and was told by Regional RN #720 that the facility has no policy. 2. Record review of Resident #81's medical record revealed an admission date of 12/05/23. Diagnoses include type II diabetes mellitus with diabetic neuropathy, neuromuscular dysfunction of bladder, and essential hypertension. Review of Resident #81's Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 15 out of 15, cognitively intact. Resident # 81 requires partial/moderate assistance with toileting hygiene, uses a wheelchair, has a neurogenic bladder with an indwelling catheter. Review of Resident #81's physician orders reveal an order to flush catheter with normal saline 60ml daily every day shift for patent catheter with start date of 11/12/2024. Review of Resident #81's care plan dated 08/05/25 revealed Resident #81 has an alteration in elimination related to supra- pubic catheter, neuromuscular dysfunction with a goal Resident #81 will be clean, dry, and odor free. Interventions include irrigations as ordered, empty foley catheter bag every shift and as needed, secure foley catheter tubing to prevent accidental dislodgement, keep foley catheter bag below level of bladder to prevent backflow, and monitor for s/s of UTI: elevated temp, dysuria, flank pain, hematuria, foul smelling urine, report to MD to seek diagnosis and treatment promptly. Review of Resident #81's care plan dated 08/05/25 revealed Resident #81 is at risk for infection related to foley catheter, UTI, and S/P foley catheter change with goals including Resident #81 will remain free of signs and symptoms of infection and will not develop any UTI's. Interventions include monitor for s/s of UTI: foul smelling urine, cloudy urine, sediment, decreased output, labs as ordered, Inform physician or nurse practitioner of abnormal labs. Review of Resident #81's urology notes indicate Resident #81 had a supra-pubic catheter placed 10/07/24. Observation on 09/16/25 at 8:34 A.M. of Resident #81's room revealed a box with an open syringe, a open bottle of acetic acid, and small unopened bottle of normal saline. Record review of Resident #81's physician orders revealed a discontinued order for acetic acid irrigation solution with a discontinuation date of 10/08/24. Interview with on 09/16/25 at 8:40 A.M. with Nurse #534 verified if order for acetic acid was discontinued the bottle should have been thrown away and nurses should use a new syringe each time catheter is flushed. Interview on 09/17/2025 at 2:45 PM with Resident #81 revealed he has frequently told the nurses that the syringe used to flush his supra-pubic catheter should be a new syringe for every flush stating their urologist told them. Observation on 09/18/25 at 9:23 A.M. revealed a open syringe package in box in Resident #81's room. Interview on 09/18/25 at 9:25 A.M. with Nurse #534 verified the open syringe Resident #81's room stating staff will be using the syringe later today to flush the catheter and backtracking and (continued on next page)		

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Centers for Medicare & Medicaid Services

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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 09/24/2025
NAME OF PROVIDER OR SUPPLIER Tuscany Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 Hazelton Etna Road SW Pataskala, OH 43062	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discarding the syringe when questioned about sterility of open package. Review of the facility's policy titled Use of Indwelling Urinary Catheter/Foley Catheters dated 03/07/15 indicated for a resident with an indwelling catheter staff should use appropriate infection control practices regarding hand washing, catheter care, tubing, and the collections bag. Evaluate factors that predispose the resident to the development of urinary incontinence or the use of an indwelling urinary catheter: considerations of complications resulting from the use of an indwelling catheter such as symptoms of blockage, with associated bypassing urine, expulsion of the catheter, pain, discomfort and bleeding. Additionally, the policy stated develop and implement a plan of care that identifies interventions to minimize catheter related injuries, pain, accidental removal and obstruction of urine flow.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure residents were provided adaptive equipment to promote independence with eating. Additionally, the facility failed to ensure food residents disliked were not served to residents. This affected one resident (#79) of four residents reviewed for nutrition. The facility census was 99. Findings Include: Review of the medical record for Resident #79 revealed an initial admission date of 10/16/19 with the latest readmission of 11/30/24 with the diagnoses including but not limited to cerebral palsy, chronic respiratory failure, chronic pain syndrome, protein calorie malnutrition, anemia, anxiety disorder, gastro-esophageal reflux disease and neuropathy. Review of the plan of care dated 10/25/19 revealed the resident had the potential for alteration in nutrition and hydration related to malnutrition, dysphagia, cerebral palsy, history of gastrointestinal bleed and anxiety. Interventions included adaptive equipment as ordered, honor food preferences as able, medications as ordered, monitor consistency of diet served, obtain food preferences, provide assistance with meals/snacks as necessary, extensive assistance and provide diet as ordered. Review of the resident's meal ticket dated 09/16/25 revealed the resident disliked oatmeal, biscuit and gravy, chocolate, cereal, gravy and watermelon. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident required set-up assistance with eating. The assessment indicated the resident received a mechanically altered diet. Review of the resident's monthly physician orders for September 2025 identified orders dated 11/12/24 regular mechanical soft diet, double handled cups with spout lid, divided plate and left-hand curve utensils. On 09/16/2025 at 8:45 A.M., observation of the resident revealed his meal ticket indicated he did not like gravy however his ground sausage had brown gravy covering it. The resident was trying to use a regular fork due to the left curved utensil was not within reach. The resident was noted to only have one two handled cup on his meal tray. The resident had a glass of water in a regular cup instead of a two handled cup. On 09/16/2025 at 8:50 A.M., interview with Certified Nursing Assistant (CNA) #573 revealed the resident's water is poured into the two handled cup that had cranberry juice once he is done and the left curve utensil was not within the resident's reach to utilize. CNA #573 also verified the sausage was covered in gravy and his meal ticket specified he disliked gravy. On 09/18/2025 at 3:27 P.M., an interview with Dietary Supervisor #599 revealed if the resident disliked gravy, then he shouldn't have it on the ground sausage. She said he worked with speech and that was the recommendation. The Dietary Supervisor verified each fluid should have a lidded two handled cup and the resident should be handed the left curved utensil with set-up.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interviews and review of resident meal ticket, the facility failed to meet the nutritional needs of one resident. This affected one resident (#79) of four residents reviewed for nutrition. The facility census was 99. Findings Include: Review of the medical record for Resident #79 revealed an initial admission date of 10/16/19 with the latest readmission of 11/30/24 with the diagnoses including but not limited to cerebral palsy, chronic respiratory failure, chronic pain syndrome, protein calorie malnutrition, anemia, anxiety disorder, gastro-esophageal reflux disease and neuropathy. Review of the plan of care dated 10/25/19 revealed the resident had the potential for alteration in nutrition and hydration related to malnutrition, dysphagia, cerebral palsy, history of gastrointestinal bleed and anxiety. Interventions included adaptive equipment as ordered, honor food preferences as able, medications as ordered, monitor consistency of diet served, obtain food preferences, provide assistance with meals/snacks as necessary, extensive assistance and provide diet as ordered. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident required set-up assistance with eating. The assessment indicated the resident received a mechanically altered diet. Review of the resident's monthly physician orders for September 2025 identified orders dated 11/12/24 regular mechanical soft diet, double handled cups with spout lid, divided plate and left-hand curve utensils. Review of the resident's meal ticket dated 09/16/25 revealed the resident disliked oatmeal, biscuit and gravy, chocolate, cereal, gravy and watermelon. On 09/16/2025 at 8:45 A.M., observation of the resident revealed his meal ticket indicated he did not like gravy however his ground sausage was covered with a brown gravy. Further observation revealed the resident had one pancake and the ground sausage on his plate and the dislike for hot and cold cereal was not replaced to meet the residents' nutritional needs. On 09/16/2025 at 8:50 A.M., an interview with Certified Nursing Assistant (CNA) #573 verified the dietary department had not sent any replacement for the oatmeal not served due to the resident disliking oatmeal and cereal.		