STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365716	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grafton Oaks Nursing Center	405 Grafton Avenue Dayton, OH 45406

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to develop a baseline care plan for Resident #91. This affected one (Resident #91) of 14 sampled residents reviewed for baseline care plans.Findings include:Medical record review revealed Resident #91 admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes, and respiratory disorders. Review of Resident #91's medical record revealed no evidence of a baseline care plan. During an interview on 01/28/26 at 1:06 P.M., Licensed Practical Nurse (LPN) #6 stated a baseline care plan should be completed upon admission. LPBN #6 stated she was unable to locate a baseline care plan for Resident #91 and confirmed the resident did not have a baseline care plan. During an interview on 01/28/26 at 1:12 P.M., Registered Nurse (RN) #3 confirmed Resident #91 did not have a baseline care plan, despite being admitted on [DATE]. During an interview on 01/28/26 at 1:34 P.M., the Minimum Data Set (MDS) Nurse #600 stated the admitting nurse was responsible for completing a resident's baseline care plan during the resident's admission. MDS Nurse #600 stated the baseline care plan was needed to guide staff and ensure proper care. Per the MDS Nurse, Resident #91's baseline care plan was overdue.During an interview on 01/28/26 at 4:37 P.M., the Assistant Director of Nursing (ADON) #650 stated she was the admitting nurse for Resident #91 and confirmed she did not implement the required baseline care plan for Resident #91, adding that it was an omission. During an interview on 01/29/26 at 4:31 P.M., the Director of Nursing (DON) stated the facility had 48 hours to complete a baseline care plan after a resident's admission. The DON stated the admitting nurse was responsible for the completion of a resident's baseline care plan. The DON stated she was not able to tell why Resident #91's baseline care plan was not completed. The Administrator stated the baseline care plan was the plan developed prior to completion of the comprehensive care plan to ensure staff knew the care and services each resident required. The Administrator stated that although Resident #91 had been in the facility for eight days, the facility failed to complete the resident's baseline care plan timely and that was an error.A facility policy titled Baseline Care Plan revised 01/10/25 revealed the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. The baseline care plan will be developed within 48 hours of a resident's admission.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 observation, interview, record review, and facility policy review, the facility failed to ensure the comprehensive care plan addressed non-invasive mechanical ventilator use for two (Resident #69 and Resident #93) of three sampled residents reviewed for respiratory care. Findings include:1. Medical record review revealed Resident #69 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, and obstructive sleep apnea. The Order Summary Report with active orders as of 01/30/26, revealed an order dated 10/21/25, for auto bilevel positive airway pressure (BiPAP) (a non-invasive mechanical ventilator) every night at bedtime and as needed throughout the day during sleep. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #69 had moderately impaired cognitive skills for daily decision-making. The MDS indicated the resident used a non-invasive mechanical ventilator during the last 14 days of the assessment period. Resident #69's comprehensive Care Plan Report with an admission date of 07/18/25 revealed the care plan did not address the resident's use of a BiPAP machine. During observations on 01/27/26 at 9:55 A.M. and 01/29/26 at 3:55 P.M., Resident #69 had a BiPAP machine in their room. During an interview on 01/30/26 at 10:33 A.M., MDS Nurse #500 stated she was responsible for a resident's nursing care plans. MDS Nurse #500 reviewed Resident #69's comprehensive care plan report and confirmed the resident did not have a care plan for the use of the BiPAP machine. The MDS Nurse stated Resident #69 should have a care plan and it was important so that staff knew the resident had a BiPAP. During an interview on 01/30/26 at 1:34 P.M., the Director of Nursing stated she expected the BiPAP to be addressed on a resident's comprehensive care plan. During an interview on 01/30/26 at 2:39 P.M., the Administrator stated each department completed their own section of the comprehensive care plan, then the MDS Nurse would ensure the care plan was completed. The Administrator stated she expected the BiPAP machine to be addressed on the comprehensive care plan for Resident #69. 2. Medical record review revealed Resident #93 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure and obstructive sleep apnea. The Order Summary Report revealed an order dated 08/21/25, for Resident #93 was to wear the Bilevel Positive Airway Pressure (BiPAP) (a noninvasive mechanical ventilator) at night at bedtime for sleep apnea. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #93 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident used a non-invasive mechanical ventilator during the last 14 days of the assessment period. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #93's comprehensive Care Plan Report with an admission date of 08/20/25 revealed the care plan did not address the resident's use of a BiPAP machine. During an interview on 01/30/26 at 1:26 P.M., the MDS Nurse #500 acknowledged Resident #93's care plan did not have any interventions related to the resident's use of the BiPaP machine. A facility policy titled Comprehensive Care Plans, revised 01/10/25, revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. This deficiency represents non-compliance investigated under Complaint Number 2627520.

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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, staff interview, record review, and facility policy review, the facility failed to specify the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department for Resident #40. This affected one (Resident #40) of two sampled residents reviewed for fluid restriction. Findings include:Medical record review revealed Resident #40 was admitted to the facility on [DATE]. Diagnoses included supraventricular tachycardia, systolic congestive heart failure, cardiomyopathy, and hypertension. The Care Plan Report included special instructions for a 2,000 milliliter (ml) fluid restriction. The Care Plan Report did not include a breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department. Resident #40's Order Summary Report with active orders as of 01/29/26, revealed an order dated 12/26/24 for a 2,000 ml fluid restriction diet. The Order Summary Report did not include a breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department. Resident #40's medication administration record (MAR) for 11/2025, 12/2025, and 01/2026, revealed no evidence to indicate staff monitored the fluids offered and/or consumed by the resident. During an observation on 01/29/26 at 8:15 A.M., Resident #40's breakfast tray contained 120 ml of orange juice, 240 ml of milk, and a 28-ounce plastic water pitcher that contained fluids. During a concurrent observation and interview on 01/29/26 at 8:35 A.M., Licensed Practical Nurse (LPN) #11 noted Resident #40 had a plastic water pitcher on their overbed table that contained approximately 240 ml of water. LPN #11 stated that Resident #40 consumed 120 ml of water with their morning medication administration on 01/29/26. LPN #11 stated she was not aware the resident had a physician's order for a fluid restriction. LPN #11 confirmed the resident's MAR for 01/2026 did not record the amount of fluids nursing staff could provide, and there was no place to document the amount of fluids consumed. During an interview on 01/29/26 at 8:52 A.M., LPN Case Manager #13 stated when a resident received an order for fluid restriction, the physician wrote the order and sometimes included the amount nursing and dietary could provide, but when the order did not include those instructions, the Registered Dietitian (RD) would calculate that. During an interview on 01/29/26 at 10:31 A.M., Dietetic Technician (DT) #505 stated if a resident had a physician's order for fluid restriction, she was responsible to calculate the amount of fluids nursing and dietary departments could provide to the resident and place the calculation in the computer for each department to be aware of. DT #505 stated this would also populate on the resident's MAR so that the nurse could record the amount of fluid received per shift. DT #505 reviewed Resident #40's medical record and stated that she saw the physician's order for fluid restriction in the computer and saw that she recorded the resident was on a fluid restriction in 11/2025 but confirmed she did not break down the order for the fluids provided for each department so this did not show up on the MAR for nursing to record the amount of fluids received each shift. DT #505 stated she did not have an explanation for this. During an interview on 01/30/26 at 2:57 P.M., Registered Dietitian (RD) #610 stated the DT was responsible to divide fluids between the nursing and dietary department for residents with a physician's order for fluid restriction. RD #610 stated that if a resident had an order for fluid restriction, the DT would divide the fluids between nursing and dietary, talk to the resident to find out preferences on how the fluid would be divided, answer any questions of the resident, and relay to nursing and dietary how the fluids would be divided. During an interview on 01/29/26 at 9:21 A.M., the Director of Nursing (DON) confirmed the MAR for Resident #40 did not have a task in place for the nurse to record the amount of fluids consumed, and the physician's order did not break down the amount of fluids provided per department. A facility policy titled Fluid Restriction revised 01/10/2025 revealed it is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's order. Compliance Guidelines included the nurse will obtain and verify the physician's order for the fluid restriction and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department, and will be recorded on the medication record or other format as per facility protocol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365716	A. Building B. Wing	02/10/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure a bi-level positive airway pressure (BiPAP) mask was stored properly when not in use for one (Resident #69) of two sampled residents reviewed for respiratory care. Findings include:Medical record review revealed Resident #69 admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, and obstructive sleep apnea.A quarterly Minimum Data Set (MDS assessment dated [DATE], revealed Resident #69 had moderately impaired cognitive skills for daily decision-making. The MDS indicated the resident used a non-invasive mechanical ventilator during the last 14 days of the assessment period. Resident #69's Order Summary Report with active orders as of 01/30/26, revealed an order dated 10/21/25, for auto bilevel positive airway pressure (BiPAP) (a non-invasive mechanical ventilator) every night at bedtime and as needed throughout the day during sleep.During an observation on 01/27/26 at 9:55 A.M., Resident #69's BiPAP mask was attached to the machine, located on the resident's bedside table, and it was uncovered. During an observation on 01/29/26 at 3:55 P.M., Resident #69's BiPAP mask was on the floor at the head of the bed.During a concurrent observation and interview on 01/29/26 at 3:59 P.M., Licensed Practical Nurse (LPN) #7 stated the BiPAP mask should be stored in a plastic bag where there was not a lot of clutter when not in use. LPN #7 observed Resident #69's BiPAP mask on the floor at the head of the resident's bed and verified the BiPAP mask was not where it should be stored.During an interview on 01/30/26 at 1:34 P.M., the Director of Nursing (DON) stated if the BiPAP mask was not on the resident then it should be stored in the bag. The DON stated that once removed, the mask should be wiped down before putting it in the bag to store until next use. The DON stated she expected the BiPAP mask to be stored in a bag when not in use.During an interview on 01/30/26 at 2:39 P.M., the Administrator stated she expected the BiPAP masks to be cleaned and stored in a bag or covered for sanitation purposes.An undated facility policy titled CPAP [continuous positive airway pressure]/BiPAP Therapy, revealed under qquipment storage, it stated to store clean, dry equipment in a labeled, breathable container. Keep away from sinks, toilets, and contaminated surfaces.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, document review, and facility policy review, the facility failed to ensure their medication error rate was not greater than five percent (%). There were four errors out of 25 opportunities, which resulted in a medication error rate of 16%. This affected three (Residents #2, #15, and #44) of five residents observed for medication administration.Findings include:1. Medical record review revealed Resident #15 admitted to the facility on [DATE]. Diagnoses included chronic embolism and thrombosis of bilateral lower extremity and stage II chronic kidney disease.Resident #15's Order Summary Report, with active orders as of 01/28/26, revealed an order dated 03/29/24 for aspirin 81 milligrams (mg) oral chewable tablet, give 81 mg by mouth one time a day for deep vein thrombosis prevention; an order dated 09/06/24, that specified, May crush medications or open capsules as needed unless contraindicated; and an order dated 09/15/25, for potassium chloride extended release 10 milliequivalent (mEq) oral tablet, give one tablet by mouth one time a day for chronic kidney disease.During medication administration observation on 01/28/26 at 9:05 A.M., Registered Nurse (RN) #3 administered Resident #15's medications, to include enteric coated aspirin 81 mg and potassium chloride 10 mEq. RN #3 crushed Resident #15's medications prior to administering the medications in chocolate pudding to the resident. During an interview on 01/28/26 at 9:35 AM, RN #3 looked at the potassium card for Resident #15 and stated, It does not say do not crush. RN #3 stated she did not know if enteric coated was the same as chewable.The undated package insert for potassium chloride 10 mEq published by the United States Food and Drug Administration, specified, To take each dose without crushing, chewing or sucking the tablets.The undated package insert for enteric coated aspirin, specified, Do not chew, crush, or cut this medication. 2. Medical record review revealed Resident #44 admitted to the facility on [DATE]. Diagnoses included cerebral infarction and acute ischemic heart disease.Resident #44's Order Summary Report, with active orders as of 01/28/26, revealed an order dated 03/22/24 for aspirin 81 milligrams (mg) oral chewable tablet, give one tablet by mouth one time a day for heart disease, and an order dated 09/06/24, that specified May crush medications or open capsules as needed unless contraindicated.During medication administration observation on 01/28/26 at 9:18 A.M., Registered Nurse (RN) #3 administered Resident #44's medications, to include enteric coated aspirin 81 mg tablet. RN #3 crushed Resident #44's medications prior to administering the medications in chocolate pudding to the resident.During an interview on 01/28/26 at 9:24 A.M., RN #3 verified she crushed all of Resident #44's medications and administered the crushed medications with pudding. RN #3 stated the physician orders indicated may crush or open unless contraindicated. RN #3 acknowledged medications such as potassium could not be crushed but did not know what other medications should not be crushed. The undated package insert for enteric coated aspirin, specified, Do not chew, crush, or cut this medication. 3. Medical record review revealed Resident #2 admitted to the facility on [DATE] and had a diagnosis of constipation.Resident #2's Order Summary Report, with active orders as of 01/29/26, revealed an order dated 01/25/23 for senna 8.6 milligrams (mg) oral tablet, give one table by mouth two times a day for constipation.During medication administration observation on 01/28/26 at 4:11 P.M., Licensed Practical Nurse (LPN) #7 administered Resident #2's medications, to include Senna Plus one tablet to Resident #2. During a concurrent observation and interview on 01/28/26 at 4:41 P.M., LPN #7 obtained the bottle of Senna Plus and confirmed that was the bottle she used to administer the medication to Resident #2. LPN #7 reviewed and confirmed the physician order was for one tablet twice a day of senna oral tablet 8.6 mg. LPN #7 stated the active ingredients in the Senna Plus bottle were docusate sodium and sennosides. LPN #7 stated the medication was not the same as senna 8.6 mg. LPN #7 stated the wrong medication or dose could cause problems and verified she did not follow the physician's orders.During an interview on 01/29/26 at 2:15 P.M., the Director of Nursing (DON) stated there was a difference between senna and Senna Plus. The DON (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated her expectation was for the facility medication error rate to be less than 5%.During an interview on 01/30/26 at 2:39 P.M., the Administrator stated the process for medication administration was to follow the physician orders. The Administrator stated she expected the medication error rate to be less than 5%.A facility policy titled Medication Administration revised 01/10/25 revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure Resident #69's physician orders were transcribed to the medication administration record/treatment administration record. This affected one (#69) of 24 residents reviewed for medical record accuracy. Findings include:Medical record review revealed Resident #69 admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, and obstructive sleep apnea.A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had a Staff Assessment for Mental Status (SAMS), that indicated the resident had moderately impaired cognitive skills for daily decision-making. The MDS indicated the resident used a non-invasive mechanical ventilator during the last 14 days of the assessment period. Resident #69's Order Summary Report with active orders as of 01/30/26, revealed an order dated 09/18/25 to clean the resident's BiPAP mask daily with warm soapy water and allow to air dry every day shift. Resident #69's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the timeframe 01/01/26 to 01/31/26, revealed no evidence of a transcription of the physician's order to clean the resident's BiPAP mask daily with warm soapy water and allow it to air dry every day shift. During an interview on 01/29/26 at 3:59 P.M., Licensed Practical Nurse (LPN) #7 stated the nurses were responsible for cleaning a resident's BiPAP mask.During a telephone interview on 01/30/26 at 4:31 A.M., LPN #8 stated the cleaning of a resident's BiPAP mask was signed off by the nurse who cleaned the BiPAP mask on the resident's TAR then placed in a bag.During an interview on 01/30/26 at 1:34 P.M., the Director of Nursing stated the physician order should be transcribed on to the resident's MAR or TAR. During an interview on 01/30/26 at 2:39 P.M., the Administrator stated if the nurses obtained physician orders either from the hospital or the physician, they should transcribe the physician order in the system to the resident's MAR. The Administrator stated that when staff received the physician order for the BiPAP and its cleaning, they should have transcribed the order to the resident's MAR or TAR. The Administrator stated the nurses were responsible for the transcription of orders.A facility policy titled Documentation in Medical Record revised 01/10/25 revealed each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessment, observation, and services provided in the resident's medical record in accordance with state law and facility policy.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure the brakes on a resident's wheelchair was maintained in a safe and functional manner for one (Resident #67) of three sampled residents reviewed for patient care equipment. Findings include:Medical record review revealed Resident #67 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction affecting right dominant side, abnormalities of the gait and mobility, and polyarthritis. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 had intact cognition and utilized a wheelchair. During a concurrent observation and interview on 01/27/26 at 11:26 A.M., Resident #67's left brake handle of their wheelchair dangled from the seating bar. The left wheelchair brake handle was non-functioning as the resident was unable to apply pressure to prevent the wheel from moving. Resident #67 stated their left wheelchair brake had been broken for a few months. Resident #67 stated they grabbed the wheel with their bare hand to stop the wheelchair from moving forward. Resident #67 stated the former Maintenance Director was aware of the broken brake and they were told the facility would order replacement parts. During an interview on 01/30/26 at 8:26 A.M., Certified Nursing Assistant (CNA) #9 confirmed she was informed of Resident #67's broken wheelchair brake handle. CNA #9 stated the brake had been broken since 11/2025 and the former Maintenance Director was aware. CNA #9 stated a work order had been submitted for repairs and she believed the facility was awaiting parts to repair. Review of the facility records revealed no evidence of a work order related to Resident #67's wheelchair brake handle. During an interview on 01/30/26 at 12:41 P.M., Maintenance Director #620 stated he was unaware of Resident #67's broken brake handle until when the Director of Nursing notified him on 01/30/26. According to Maintenance Director #620, Resident #67's broken wheelchair handle was reported to the former Maintenance Director and he did not know why it had not been resolved. The Maintenance Director stated he fixed the resident's wheelchair, it was resolved, and he was sorry the resident had to wait as that never should have happened. During an interview on 01/30/26 at 3:47 P.M., the Administrator stated it was her expectation for all staff to inform maintenance or management of a resident issue. An undated facility policy titled Maintenance request/ Environment revealed the Maintenance and Housekeeping department will try to complete work orders as quickly as possible depending on the day, staffing, parts, and materials available and severity of the request. Hazardous and safety concerns will be considered urgent and when all possible addressed the same day.