STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516 Based on observation, medical record review, and staff interview, the facility failed to ensure urinary catheter collection bags were covered to maintain dignity. This affected one (#195) of four residents reviewed for respect and dignity. The census was 41. Findings included: Review of Resident #195's medical record revealed the resident was admitted on [DATE] with diagnoses of hypertension, lymphedema, and cellulitis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #195 was cognitively intact and admitted with indwelling urinary catheter. Observation of Resident #195 on 02/24/25 at 11:39 A.M. revealed the resident had no cover in place on the urinary catheter collection bag. Interview with Certified Nurse Aide (#704) verified Resident #195's urinary catheter collection bag did not have a cover to maintain dignity at the time of the observation. This deficiency represents non-compliance investigated under Complaint Number OH00160883.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, observation, staff interview, and policy review, the facility failed to determine if residents were clinically appropriate to self-administer their medications. This affected two (#7 and #10) of four residents observed during medication administration. The facility census was 41. Findings include: 1. Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses including type two diabetes, chronic kidney failure, bipolar disorder, long term (current) drug therapy, and hypertension. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact and required setup or clean-up assistance for activities of daily living (ADLs). Review of Resident #7's current physician orders revealed no order for self-administration of medication. Review of Resident #7's care plan dated 02/21/25 revealed no care plan for self-administration of medications. Review of assessments revealed no self-administration of medications assessment was completed for Resident #7. Observation of medication administration with Licensed Practical Nurse (LPN) #905 on 02/25/25 at 7:50 A.M. revealed Resident #7 administered her own Lantus (long-acting insulin) 50 units subcutaneous (SQ) without priming the insulin pen prior to dialing up the dose, Humalog (short acting insulin) 15 units SQ without priming the insulin pen prior to dialing up the dose, the inhaled medication for chronic obstructive pulmonary disease (COPD) Trelegy 100/62.5/25 micrograms (mcg), and cyclosporine 0.05 percent (%) eye drops. LPN #905 dialed up two extra units and primed the insulin pens prior to the resident administering the dose into her abdomen. Resident #7 also checked her own blood sugar with the glucometer handed to her by the nurse and checked her blood pressure with the wrist cuff provided by the nurse. Interview on 02/25/25 at 10:37 A.M. with the Director of Nursing (DON) verified Resident #7 did not have a self-administration of medication assessment or physician order to self-administer medications. 2. Review of the medical record for Resident #10 revealed admitted [DATE] with diagnoses including end stage renal disease, type two diabetes, major depressive disorder, anxiety, fibromyalgia, insomnia, and convulsions. Review of the MDS assessment dated [DATE] revealed Resident #10 was cognitively intact. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 01/07/25 revealed Resident #10 had no care plan or mention of self-administration of medication. Review of Resident #10's current physician orders revealed the resident was ordered the anesthetic medication Lidocaine patch to apply one patch to the right thigh daily and the inhaled decongestant medication fluticasone (Flonase) nasal suspension 50 mcg twice daily with instructions the medication may be left at the bedside. There were no orders for self-administration of medications. Review of assessments revealed no self-administration medication assessment completed for Resident #10. Interview on 02/25/25 at 7:30 A.M. with LPN #905 revealed Resident #10 kept her Flonase at the bedside and will administer it after breakfast. LPN #905 stated the resident usually administered her own insulin and placed her Lidocaine patches on her body where she wanted them. Observation and interview on 02/25/25 at 7:35 A.M., during medication administration for Resident #10, revealed the resident did not administer her own insulin, but did placed two Lidocaine 4% patches to her left lower extremity after removing the old patches. Interview with LPN #905 verified the resident removed her old patches from yesterday prior to placing the new patches. Interview on 02/25/25 at 10:41 A.M. with the DON verified Resident #10 did not have a self-administration assessment completed prior to today. The DON verified Resident #10 was not documenting the administration of her Flonase as the nurses were doing that. The DON verified the resident had no physician order to self-administer medications. Review of the undated policy titled, Resident Self-Administration of Medications, revealed the interdisciplinary team (IDT) will assess for safety of self-administrating of medications or use of a continuous monitoring device including the following cognitive functioning, physical ability, and emotional ability. Assessments will include addressing the following and documenting in the care plan storage of the medication, responsible party for storage of medication, documenting the administration of drugs, location of where the drug will be administered, and the residents' ability to apply and monitor a continuous glucose monitoring device. A physician or provider order is required for residents to self-administer medication.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516 Based on observation, medical record review, staff interview, and policy review, the facility failed to provide privacy during a mechanical lift transfer. This affected one (#27) of one residents reviewed for privacy. The census was 41. Findings included: Review of Resident #27's medical record revealed the resident was admitted on [DATE] with diagnoses of myocardial infarction, dysphagia, Alzheimer's disease, and depression. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 was cognitively impaired, had limited range of motion with the upper and lower extremities, and was wheelchair bound. Review of Resident #27's current plan of care revealed Resident #27 was to be transferred by a mechanical (Hoyer) lift at all times and was dependent with all care using one to two helpers. Observation on 02/24/25 at 11:11 A.M. revealed Certified Nurse Aide (CNA) #604 and CNA #704 were inside Resident #27's room with the door open while placing a Hoyer lift sling under the resident. CNA #604 and CNA #704 rolled Resident #27 from side to side with the resident's dress above her incontinence brief. After the Hoyer lift sling was in place, CNA #704 walked away from bedside to get the Hoyer lift while CNA #604 remained at the bedside opposite the open door to the hallway. Further observation revealed Resident #27 remained in bed with her dress moved further up toward her head with her full breast exposed. CNA #604 and CNA #704 lifted Resident #27 using the Hoyer lift into a wheelchair with her incontinence brief exposed all while the door remained open to the hallway. Interview with CNA #604 and CNA #704 verified they did not close the door to Resident #27's room while providing care. Review of an undated facility policy titled, Resident Rights, revealed residents have the right to have their privacy respected when treatment, medication, or care is being administered including the door closed or privacy curtain drawn.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on medical record review, review of hospital documentation, staff interview, nurse practitioner interview, and review of the Centers for Disease Control and Prevention (CDC) website, the facility failed to ensure medication orders for treatment of Influenza (Flu) Type A were timely initiated for a resident which caused a significant medication error. Actual harm occurred to Resident #13 when the resident exhibited a change in condition, tested positive for Influenza Type A, and was evaluated by a nurse practitioner who recommended the implementation of an antiviral medication which was not ordered timely or administered. This resulted in Resident #13 becoming difficult to arouse and responded only to painful stimuli. Resident #13 required hospitalization and was diagnosed with renal insufficiency, hypoxia, and pneumonia. This affected one (#13) of three residents reviewed for Influenza Type A infections. The census was 41. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE]. The resident was admitted with diagnoses including chronic obstructive pulmonary disease (COPD), bipolar disorder, chronic kidney disease stage three, heart failure, and atherosclerotic heart disease. The resident was hospitalized on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had moderately impaired cognition, required set up assistance for meals, and maximum assistance with toileting hygiene, bed mobility, and transfers. Review of a progress note dated 02/14/25 documented by Certified Nurse Practitioner (CNP) #907 revealed Resident #13 had an acute visit due to increased cough and shortness of breath. Further review revealed the resident tested positive for Influenza Type A with a plan to start Resident #13 on the antiviral medication Tamiflu 30 milligrams (mg) daily. Review of Resident #13's physician orders revealed no order for Tamiflu until 02/20/25. Review of a nursing progress note dated 02/20/25 revealed a change in condition report for Resident #13 which indicated she was difficult to arouse and only responded to painful stimuli. It was recommended the resident be sent out to the emergency room (ER). Review of a subsequent entry note revealed Resident #13 was sent to the hospital at 10:28 A.M. Review of the hospital admission documentation dated 02/20/25 revealed Resident #13 had an admitting diagnoses of acute on chronic renal insufficiency, hypoxia (decreased perfusion of oxygen to the tissues), pneumonia, and Influenza Type A. Review of a chest x-ray image revealed the resident had patchy airspace opacities (increased density) in the bilateral lower lobes (of the lungs) concerning for multifocal pneumonia. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Interview on 02/25/25 at 12:34 P.M. with CNP #907 verified she assessed Resident #13 on 02/14/25 and normally put her own orders in for residents, but acknowledged she forgot to put in the Tamiflu order for Resident #13. CNP #907 stated she discussed her plan with nursing staff prior to her leaving the facility, and later in the day she realized she forgot to place the order into the electronic chart. CNP #907 stated she then called the facility and spoke with Registered Nurse (RN) #610 and requested she enter the Tamiflu order for Resident #13. Interview on 02/25/25 at 2:12 P.M. with the Director of Nursing (DON) verified Resident #13 tested positive for Influenza Type A on 02/14/25. The DON stated she was unsure why Tamiflu was not started at the time of the positive testing. The DON stated CNP #907 spoke to RN #816 prior to leaving the facility on 02/14/25 and suggested the nurse be interviewed. The DON stated Resident #13's Tamiflu order dated 02/20/25 was ordered facility wide for prophylaxis. Interview on 02/25/25 at 2:15 P.M. with RN #816 verified CNP #907 did discuss Resident #13 with her prior to CNP #907 leaving the facility on 02/14/25. RN #816 verified CNP #907 did not indicate to her that she wanted Resident #13 to start on Tamiflu. RN #816 acknowledged nursing staff should have inquired why Resident #13 was not started on Tamiflu after her positive Influenza Type A test. Interview on 02/26/25 with Infection Preventionist (IP) #417 revealed the expectation for residents who test positive for Influenza Type A was to place them in droplet isolation, contact the physician, and start the residents on Tamiflu. IP #417 verified Resident #13 tested positive for Influenza Type A on 02/14/25 and neither she nor her nurse contacted the physician on 02/14/25 for medication orders. Interview on 02/27/25 at 8:40 A.M. with the DON acknowledged Resident #13 tested positive for Influenza Type A on 02/14/25. The DON stated CNP #907 would put in her own orders, but failed to do so for Resident #13. The DON acknowledged IP #417 had Resident #13's positive Influenza Type A test result, and stated IP #417 should serve as an additional means of ensuring proper treatments were in place. Review of the CDC website at, https://www.cdc.gov/flu/treatment/index.html, revealed a webpage titled, Treatment of the Flu, dated 09/09/24. Further review of the CDC guidance revealed antiviral drugs should be started as soon as possible after symptoms begin. Studies show that treatment of flu with antiviral medications works best when started within two days after flu symptoms begin and can lessen symptoms and shorten the time you are sick by about a day. Antiviral drugs can make illness milder and shorten the time a person is sick. They might also prevent some flu complications, like pneumonia. Starting antiviral treatment shortly after symptoms begin also can help reduce some flu complications. This deficiency represents non-compliance investigated under Master Complaint Number OH00161598 and Complaint Number OH00160883.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516 Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure residents were provided assistive drinking devices as care planned. This affected one (#15) of one residents reviewed for assisted eating devices. The census was 41. Findings include: Review of Resident #15's medical record revealed the resident was admitted on [DATE]. Diagnoses included nontraumatic intracerebral hemorrhage, contracture of the right hip, contracture of the left hip, diabetes mellitus type II, neuromuscular dysfunction of the bladder, and left hand pain. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was cognitively impaired required assistance with activities of daily living (ADLs), and had frequent pain. Review of a care plan dated 12/03/24 revealed Resident #15 had a potential for altered nutrition and had interventions for build up utensils for eating and a Kennedy cup (a lightweight, spill-proof drinking cup) for liquids at bedside table and with all meals. Observation on 02/24/25 at 12:30 P.M. revealed Resident #15 did not have a Kennedy cup on the tray with the resident's meal. Further observation revealed Resident #15 had an open, half-full can of soda pop and a 64 ounce cup with a handle and lid, but no straw, on the overbed table in front of the resident. Interview with Certified Nurse Aide (CNA) #604 verified Resident #15 did not have a Kennedy cup at the time of the observation. Observation on 02/24/25 at 5:30 P.M. revealed Resident #15 did not have a Kennedy cup in the dining room and the resident was served three separate drinks all contained in regular cups. Interview with CNA #604 verified Resident #15 did not have Kennedy cups at the time of the observation. Interview on 02/24/25 at 5:40 P.M. with Dietary Manager (DM) #718 revealed no staff came into the kitchen to request a Kennedy cup for Resident #15 to use in his room. DM #718 verified Kennedy cups were available every day at all times. Review of the undated policy titled, Assistive Eating Devices, revealed it is the policy of the facility to provide assistive eating devices to residents with limited arm mobility, grasp, range of motion or coordination as recommended by nursing or therapy to promote independence in drinking and eating to their maximum ability. Staff are to be educated for placement and use to assist the resident.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on medical record review, review of arbitration agreements, and staff and resident interviews, the facility failed to ensure arbitration agreements were explained and presented to residents with appropriate cognition to understand the document content. This affected one (#145) of four residents reviewed for arbitration agreements. The census was 41. Findings include: Review of the medical record for Resident #145 revealed an admitted [DATE] with diagnoses including moderate dementia with agitation, atrial fibrillation, chronic obstructive pulmonary disease (COPD), hypertension, legal blindness, bilateral unspecified hearing loss, heart failure, cognitive communication deficit, and unspecified hearing loss bilateral. Review of a previous admission Minimum Data Set (MDS) assessment, completed 12/16/24 while Resident #145 in a different facility, the resident was assessed with severe cognitive impairment. Review of an arbitration agreement document revealed the parties understand, acknowledge, and agree by entering into this arbitration agreement they are voluntarily selecting arbitration as the method of resolving their disputes without resorting to lawsuits or the courts, and they are giving up and waving their constitutional right to have their disputes decided in a court of law before a judge and jury, the opportunity to present their claims as a class action and/or to appeal any decision or award of damages resulting from the arbitration as provided herein. By checking this box and signing this arbitration agreement, they acknowledge they understand the terms of the arbitration agreement. Further, by signing this arbitration agreement, they are agreeing to have any claims or disputes between the resident or his or her representative and the facility as set forth herein, decided through binding arbitration and they are giving up their right to a jury or court trial. An X was placed on this box. Review of the arbitration agreement document revealed Resident #145 signed the agreement on 02/06/25. Review of the resident signature line revealed a first name that was legible and the last name was illegible. Review of an admission MDS assessment dated [DATE] revealed Resident #145 was assessed with severe cognitive impairment. Review of a care plan dated 02/20/25 revealed Resident #145 had impaired cognitive function with interventions including to administer medications as ordered, communicate with the resident, family, or caregiver regarding the resident's capabilities and needs, discuss concerns about confusion, disease process, nursing home placement with resident, family, or caregiver, offer two to three step instructions when completing basic tasks, and keep routines as consistent as possible in order to decrease confusion. Review of a resident profile revealed Resident #145 had a Durable Power of Attorney (DPOA). (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/25/25 at 3:27 P.M. with Resident #145 revealed the resident was alert and oriented to self only. Resident #145 did not know what day or month it was and thought he was at the hospital. Resident #145 could not state what town he was in. Resident #145 stated he remembered signing paperwork when he came to the building, but did not know what an arbitration agreement was. Interview on 02/26/25 at 3:53 P.M. with Admissions Director (AD) #723 revealed she attempts to review previous facility or hospital documentation to determine a resident's cognition or asked questions such as the resident's name, the day of the week, and where they are to gauge cognitive function. AD #723 stated she would also get family input as well to determine a resident's ability to sign paperwork. AD #723 stated she obtained Resident #145's information from documentation from entities where the resident received care prior to admission to the facility. AD #723 stated Resident #145's DPOA lived out of state and she contacted her as well. AD #723 verified there was no documentation regarding the conversation. AD #723 stated Resident #145 was a lot different when he came in from how he was now. AD #723 stated the resident was able to tell her his name, where he was, what day it was, and appeared to understand what she was asking. AD #145 stated she sat beside the resident's, placed the iPad (handheld electronic device) in front of the resident, and read the admission packet off to him and have the resident sign the documents after each section. AD #145 verified the resident had diagnoses of legal blindness, dementia, and hearing loss in bilateral ears. AD #723 stated Resident #145 heard better in the right ear. AD #723 stated the resident did not have his hearing aides as they were lost in the transition from nursing homes, but new ones were ordered. AD #723 stated if Resident #145 was the way he was now she would have never had him sign his own paperwork.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on observation, medical record review, review of infection control tracking documents, staff interview, and facility policy review, the facility failed to ensure proper infection control monitoring was timely and accurately maintained during an active influenza outbreak and failed to ensure a urinary catheter was maintained in a manner to prevent infection. This had the potential to affect all 41 residents residing in the facility. The census was 41. Findings include: 1. Review of the facility's infection control surveillance tracking revealed the document was not completed for February 2025. Interview on 02/26/25 at 124 P.M. with Infection Preventionist (IP) #417 acknowledged the facility was in an influenza outbreak and the method the facility utilized to track the infections was not updated for February 2025. IP #417 stated an employee was the first person to test positive for influenza on 02/11/25 and the next positive test was a resident on 02/13/25. IP #417 was not able to provide tracking information for the influenza outbreak at the time of the interview. IP #417 stated the physician was in the facility weekly on Thursdays and was made aware of the positive tests on 02/13/25. Interview on 02/27/25 at 8:40 A.M. with the Director of Nursing (DON) acknowledged the infection control surveillance tracking record was not accurately completed for February 2025. Review of the facility policy titled, Antibiotic Stewardship Plan, dated 05/01/17, revealed the Infection Preventionist (IP) would collect and analyze infection surveillance data to monitor and support antibiotic stewardship activities. The IP nurse would follow, track, and monitor residents for the purpose of treatment follow up. 51516 2. Review of Resident #195's medical record revealed the resident was admitted on [DATE] with diagnoses of hypertension, lymphedema, and cellulitis. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #195 was cognitively intact and was admitted with an indwelling urinary catheter. Observation of Resident #195 on 02/24/25 at 11:39 A.M. revealed the resident's urinary catheter collection bag was bag laying on the floor without a barrier. Further observation revealed Certified Nurse Aide (CNA) #704 walked into the room with a lunch tray and rolled a bedside table over the resident's urinary catheter collection bag. Interview with CNA #704 on 02/24/25 at approximately 11:40 A.M. verified Resident #195's urinary catheter collection bag was laying directly on the floor with no barrier and the bedside table was rolled over it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an undated catheter care policy revealed the catheter bag should not be on the floor.