

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER Grande Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 24579 Broadway Ave Oakwood Village, OH 44146	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442</p> <p>Based on resident and staff interviews, record review and facility investigation records, the facility failed to ensure staff maintained a professional demeanor when interacting with and around residents to ensure they are treated with dignity and respect at all times. This affected two (Resident #103 and #116) of three residents reviewed for dignity and respect. The facility census was 43.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #103 revealed an admitted [DATE]. Diagnoses included but were not limited to dependence on a respirator, morbid obesity, unspecified protein-calorie malnutrition, type II diabetes, anxiety disorder, schizophrenia, and epilepsy.</p> <p>Review of 04/10/24 annual Minimum Data Set (MDS) 3.0 for Resident #103 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated Resident #103 was cognitively intact. Review of activities of daily living (ADLs) for Resident #103 revealed he required set up for eating, oral hygiene, upper dressing, personal hygiene, chair to bed transfer, toilet transfer, required moderate assist for toileting, bathing, and was independent with his wheelchair.</p> <p>Review of Resident #103's witness statement conducted by the Administrator dated 04/26/24 from a facility investigation on the Director of Nursing's (DON) conduct while in the facility revealed revealed the resident was sitting in the dining room and saw the DON who appeared to look angry but didn't hear him talking to staff.</p> <p>Interview on 05/20/24 at 5:42 A.M. with Resident #103 confirmed when the former DON entered the building on 04/25/24 around 2:00 A.M. he yelled at him stating, you need to [expletive] be in your bed because all these people are calling me telling residents are running amuck.</p> <p>Interview on 05/20/24 at 6:12 A.M. with Resident #100 confirmed during the night of 04/25/24 the former DON and RN #267 walked into the TV room where she was with Resident #141. Shortly after, Resident #100 stated she heard yelling down on the skilled unit and heard the former DON yelling at Resident #103 telling him he needed to go to bed. A few minutes later, Resident #100 heard the former DON yelling at RT #93 and stated, What the expletive is going on?</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #116 revealed an admitted [DATE]. Diagnoses included but are not limited to acute respiratory failure, cardiac arrest, morbid obesity, unspecified sever protein-calorie malnutrition, tracheostomy status, anoxic brain damage, congestive heart failure, gastrostomy status, and persistent vegetative state.</p> <p>Review of 04/17/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #116 revealed she is in a persistent vegetative state. Review of activities of daily living (ADLs) revealed Resident #115 was dependent for all ADLs.</p> <p>Interview was unable to be obtained with Resident #116 due to her cognitive impairment.</p> <p>Review of a facility investigation following suspicion of DON and Registered Nurse (RN) #267 being impaired in the facility revealed the following:</p> <p>Review of the witness statement dated 04/26/24 timed at 2:58 P.M. from Licensed Practical Nurse (LPN) #220 revealed on 04/26/24 at approximately 2:00 A.M. she was at the desk charting when the former DON and RN #267 came on the unit smelling of alcohol and proceeded to conduct rounds on the unit.</p> <p>Review of the witness statement dated 04/26/24 timed at 2:14 P.M. from State tested Nursing Assistant (STNA) #27 revealed on 04/26/24 the former DON and another person came to the unit during the night and appeared to be drunk or high and smelled.</p> <p>Review of the witness undated statement from the former DON revealed on 04/26/24 he did an unexpected night shift check related to customer service concerns reported earlier that week.</p> <p>Review of the employee file for the former DON revealed a resignation letter dated 04/18/24 with last working day of 05/26/24. No disciplinary action was found in the employee record.</p> <p>Review of the investigation revealed the facility did not obtain a statement from RN #267.</p> <p>Phone interview on 05/09/24 at 4:01 P.M. with State tested Nurse Aide (STNA) # 14 stated on 04/26/24 around 2:00 A.M. the former DON and RN #267 came to the facility, STNA #14 could smell alcohol on them.</p> <p>Interview on 05/13/24 at 8:50 A.M. with the Administrator revealed she first became aware of the reported concerns regarding the former DON and alleged intoxication from corporate on 04/26/24 around 10:00 A.M. the following morning.</p> <p>Phone interview on 05/13/24 at 10:11 A.M. with the former DON confirmed he came to the facility around 2:00 A.M. on 04/26/24. The DON denied being under the influence of alcohol or drugs when he entered the facility.</p> <p>Interview on 05/13/24 at 10:26 A.M. with the Administrator revealed the facility received the former DON's resignation letter on 04/26/24 and his last day of work was 04/26/24. The Administrator stated the date on the resignation letter was an error and should have been 04/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/14/24 at 8:33 A.M. with DON #33 confirmed she was not aware of the incident on 04/26/24 until she arrived at work the following morning. DON #33 confirmed employees should have immediately contacted the Administrator, DON, or supervisor to report concerns to begin an investigation.</p> <p>Interview on 05/20/24 at 5:35 A.M. with LPN #220 revealed around 2:00 A.M. on 04/25/24 the former DON came to the facility with Registered Nurse (RN) #267, smelled of alcohol, and were going room to room checking on residents. LPN #220 stated the former DON was yelling at staff but did not observe him yelling at any residents. LPN #220 stated she did not call management after the incident but did write a written statement and put it under the door of Human Resources before she left her shift the morning of 04/26/24.</p> <p>Interview on 05/20/24 at 5:39 A.M. with STNA #27 revealed the former DON came to the facility on the night of 04/25/24 with RN #267 going room to room and checking on residents and was yelling at staff. STNA #27 stated since the LPN #220 was the night supervisor, she did not notify anyone and the following morning, the facility requested she write a written statement and she provided it.</p> <p>Interview on 05/20/24 at 5:42 A.M. with Resident #103 confirmed when the former DON entered the building on 04/25/24 around 2:00 A.M. he yelled at him stating, you need to [expletive] be in your bed because all these people are calling me telling residents are running amuck.</p> <p>Interview on 05/20/24 at 5:46 A.M. with Respiratory Therapist (RT) #93 revealed when he came out of resident room, he heard yelling in Resident #116's room and when he approached, he heard the former DON yell for the respiratory therapist. When RD #93 entered, former DON yelled at him and said, What the expletive is this? RT #93 stated he could smell alcohol on the former DON when he approached him. The former DON was pointing at Resident #116's corrugated tubing for her trach mask that had some water in it. RT #93 stated Resident #116 was not struggling and her oxygen level was at 98%. RT #93 stated he did not want to escalate the situation and told the former DON, Thank you, sir, thank you sir, and removed the water from the tubing. During the interaction with the former DON, RT #93 stated RN #267 was outside of the room and was trying to get the former DON to leave the building. RT #93 stated because the former DON left the building, he felt there was no immediate danger and waited to notify his supervisor at 7:00 A.M. on 04/26/24. RT #93 stated if he had not left, or if he returned, he was going to contact the police.</p> <p>Interview on 05/20/24 at 6:04 A.M. with STNA #69 confirmed the former DON was in the building on 04/25/24 with RN #267 going room to room and they left together.</p> <p>Interview on 05/20/24 at 8:26 A.M. with the Administrator confirmed the facility did not get a witness statement from RN #267 following the incident on 04/25/24 due to her leaving on vacation and also confirmed she did not get a statement after she returned.</p> <p>Attempts were made to interview RN #267 on 05/13/24 at 10:32 A.M. with request for return call. No return phone call was received. Additional phone attempt was made on 05/20/24 at 8:30 A.M. RN #267 answered and stated she was busy and would call back shortly. Third attempt was made on 05/20/24 at 9:36 A.M. with no answer. Voicemail was left with request for return phone call.</p> <p>Interview on 05/20/24 at 10:07 A.M. with the Administrator and DON #33 revealed they have not been able to get a hold of RN #267 for a statement.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 04/04/22 facility policy called; Resident Rights revealed the resident has the right to choose activities, schedules (including sleeping and waking times) and has the right to make choices about aspects of his or her life in the facility that are significant to the resident. The resident has the right to be treated with respect and dignity.</p> <p>This deficiency represents non-compliance investigated under Master Complaint number OH00153596 and Complaint number OH00153477.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>45442</p> <p>Based on interview, record review, resident and staff statements review, the facility failed to ensure staff showing signs of potential impairment was evaluated to ensure they was competent to provide resident care following suspicions of impaired behaviors by co-workers. This had the potential to affect all residents residing at the facility. The facility census was 43.</p> <p>Findings include:</p> <p>Review of a facility investigation following suspicion of DON and Registered Nurse (RN) #267 being impaired in the facility revealed the following:</p> <p>Review of the witness statement dated 04/26/24 timed at 2:58 P.M. from Licensed Practical Nurse (LPN) #220 revealed on 04/26/24 at approximately 2:00 A.M. she was at the desk charting when the former DON and RN #267 came on the unit smelling of alcohol and proceeded to conduct rounds on the unit.</p> <p>Review of the witness statement dated 04/26/24 timed at 2:14 P.M. from State tested Nursing Assistant (STNA) #27 revealed on 04/26/24 the former DON and another person came to the unit during the night and appeared to be drunk or high and smelled.</p> <p>Review of the witness undated statement from the former DON revealed on 04/26/24 he did an unexpected night shift check related to customer service concerns reported earlier that week.</p> <p>Review of the employee file for the former DON revealed a resignation letter dated 04/18/24 with last working day of 05/26/24. No disciplinary action was found in the employee record.</p> <p>Review of the investigation revealed the facility did not obtain a statement from RN #267.</p> <p>Phone interview on 05/09/24 at 4:01 P.M. with State tested Nurse Aide (STNA) # 14 stated on 04/26/24 around 2:00 A.M. the former DON and RN #267 came to the facility, STNA #14 could smell alcohol on them.</p> <p>Interview on 05/13/24 at 8:50 A.M. with the Administrator revealed she first became aware of the reported concerns regarding the former DON and alleged intoxication from corporate on 04/26/24 around 10:00 A.M. the following morning.</p> <p>Phone interview on 05/13/24 at 10:11 A.M. with the former DON confirmed he came to the facility around 2:00 A.M. on 04/26/24. The DON denied being under the influence of alcohol or drugs when he entered the facility.</p> <p>Interview on 05/13/24 at 10:26 A.M. with the Administrator revealed the facility received the former DON's resignation letter on 04/26/24 and his last day of work was 04/26/24. The Administrator stated the date on the resignation letter was an error and should have been 04/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 05/14/24 at 8:33 A.M. with DON #33 confirmed she was not aware of the incident on 04/26/24 until she arrived at work the following morning. DON #33 confirmed employees should have immediately contacted the Administrator, DON, or supervisor to report concerns to begin an investigation.</p> <p>Interview on 05/20/24 at 5:35 A.M. with LPN #220 revealed around 2:00 A.M. on 04/25/24 the former DON came to the facility with Registered Nurse (RN) #267, smelled of alcohol, and were going room to room checking on residents. LPN #220 stated the former DON was yelling at staff but did not observe him yelling at any residents. LPN #220 stated she did not call management after the incident but did write a written statement and put it under the door of Human Resources before she left her shift the morning of 04/26/24.</p> <p>Interview on 05/20/24 at 5:39 A.M. with STNA #27 revealed the former DON came to the facility on the night of 04/25/24 with RN #267 going room to room and checking on residents and was yelling at staff. STNA #27 stated since the LPN #220 was the night supervisor, she did not notify anyone and the following morning, the facility requested she write a written statement and she provided it.</p> <p>Interview on 05/20/24 at 5:42 A.M. with Resident #103 confirmed when the former DON entered the building on 04/25/24 around 2:00 A.M. he yelled at him stating, you need to [expletive] be in your bed because all these people are calling me telling residents are running amuck.</p> <p>Interview on 05/20/24 at 5:46 A.M. with Respiratory Therapist (RT) #93 revealed when he came out of resident room, he heard yelling in Resident #116's room and when he approached, he heard the former DON yell for the respiratory therapist. When RD #93 entered, former DON yelled at him and said, What the expletive is this? RT #93 stated he could smell alcohol on the former DON when he approached him. The former DON was pointing at Resident #116's corrugated tubing for her trach mask that had some water in it. RT #93 stated Resident #116 was not struggling and her oxygen level was at 98%. RT #93 stated he did not want to escalate the situation and told the former DON, Thank you, sir, thank you sir, and removed the water from the tubing. During the interaction with the former DON, RT #93 stated RN #267 was outside of the room and was trying to get the former DON to leave the building. RT #93 stated because the former DON left the building, he felt there was no immediate danger and waited to notify his supervisor at 7:00 A.M. on 04/26/24. RT #93 stated if he had not left, or if he returned, he was going to contact the police.</p> <p>Interview on 05/20/24 at 6:12 A.M. with Resident #100 confirmed during the night of 04/25/24 the former DON and RN #267 walked into the TV room where she was with Resident #141. Shortly after, Resident #100 stated she heard yelling down on the skilled unit and heard the former DON yelling at Resident #103 telling him he needed to go to bed. A few minutes later, Resident #100 heard the former DON yelling at RT #93 and stated, What the expletive is going on?</p> <p>Interview on 05/20/24 at 6:04 A.M. with STNA #69 confirmed the former DON was in the building on 04/25/24 with RN #267 going room to room and they left together.</p> <p>Interview on 05/20/24 at 8:26 A.M. with the Administrator confirmed the facility did not get a witness statement from RN #267 following the incident on 04/25/24 due to her leaving on vacation and also confirmed she did not get a statement after she returned.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Attempts were made to interview RN #267 on 05/13/24 at 10:32 A.M. with request for return call. No return phone call was received. Additional phone attempt was made on 05/20/24 at 8:30 A.M. RN #267 answered and stated she was busy and would call back shortly. Third attempt was made on 05/20/24 at 9:36 A.M. with no answer. Voicemail was left with request for return phone call.</p> <p>Interview on 05/20/24 at 10:07 A.M. with the Administrator and DON #33 revealed they have not been able to get a hold of RN #267 for a statement.</p> <p>This deficiency substantiates Master Complaint number OH00153596 and Complaint number OH00153477.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interviews, the facility failed to ensure antibiotics were administered as ordered. This finding affected two (Residents #115 and #116) of five residents reviewed for medication administration.</p> <p>Findings include:</p> <p>1. Review of Resident #116's medical record revealed the resident was admitted on [DATE] with diagnoses including dilated cardiomyopathy, ventricular tachycardia and tracheostomy status.</p> <p>Review of Resident #116's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was not interviewable.</p> <p>Review of a text message dated 04/15/24 at 3:16 P.M. provided by Licensed Practical Nurse (LPN) #202 from Nurse Practitioner (NP) #803 indicated for the nurse to administer Ertapenem one gram IM times one stat. (Ertapenem was in the starter kit.) Place an IV line and NS to be infused at 100 ml per hour for one liter. Flush the percutaneous gastrostomy (PEG) tube with 250 ml water times one stat. The text message did not identify the resident's name in the message.</p> <p>Review of Resident #116's physician orders revealed an order dated 04/16/24 for sodium chloride (normal saline or NS) infuse 100 milliliters per hour (ml/hr) intravenously (IV) every shift for dehydration for two days (one liter); and an order dated 04/16/24 for Ertapenem sodium injection (antibiotic) one gram intramuscularly (IM) in the afternoon for a wound infection for seven days.</p> <p>Review of Resident #116's medication administration records (MARS) for 04/15/24 and 04/16/24 revealed the resident was not administered the Ertapenem injection on 04/16/24 as ordered and the IV fluids were infused from 04/16/24 second shift to 04/18/24 first shift (should have been 10 hours at 100 ml per hour for 1000 ml or one liter).</p> <p>Interview on 05/13/24 at 8:19 A.M. with LPN #202 indicated she called NP #803 for Resident #115's (different resident) laboratory findings which were out of range and received an order for normal saline and for Ertapenem antibiotic injection. LPN #202 stated she put the orders in the computer and signed off the medication but did not actually administer the antibiotic medication as ordered. She stated the IV fluids were for Resident #116. She stated she was terminated for the medication error.</p> <p>Interview on 05/13/24 at 9:51 A.M. with NP #803 indicated he gave a verbal order to LPN #202 for the Ertapenem IM antibiotic, the one liter of NS IV fluids and the additional PEG flush for Resident #116. NP #803 stated LPN #202 was having difficulty understanding what he said so he texted her the information for Resident #116 on her personal cellular phone. He stated he did not normally text the information, but the nurse could not spell the antibiotic he wanted for Resident #116's increased white blood cell count.</p> <p>Interview on 05/13/24 at 10:49 A.M. with Registered Nurse (RN) Director of Clinical Services #804 confirmed Resident #116's MARS did not reveal evidence the Ertapenem antibiotic was administered as ordered and the IV fluids appeared to be infused for more than 1000 ml as ordered (one liter).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration policy dated 11/2017 revealed medications were administered by licensed nurses, or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>2. Review of Resident #115's medical record revealed the resident was readmitted on [DATE] with diagnoses including dependence on a respirator ventilator, muscle weakness and anemia.</p> <p>Review of Resident #115's MDS 3.0 assessment dated [DATE] revealed the resident was not interviewable.</p> <p>Review of a text message dated 04/15/24 at 3:16 P.M. provided by LPN #202 from NP #803 indicated for the nurse to administer Ertapenem one gram IM times one stat. (Ertapenem was in the starter kit.) Place an IV line and NS to be infused at 100 ml per hour for one liter. Flush the PEG tube with 250 ml water times one stat. The text message did not identify the resident's name in the message.</p> <p>Review of Resident #115's physician orders revealed an order dated 04/15/24 for Ertapenem sodium injection one gram inject IM one time for an infection.</p> <p>Review of Resident #115's medication administration record (MAR) dated 04/15/24 revealed the Ertapenem was signed off as administered to the resident by LPN #202 at 5:32 P.M.</p> <p>Interview on 05/13/24 at 8:19 A.M. with LPN #202 indicated she called NP #803 for Resident #115's laboratory findings which were out of range and received an order for normal saline and for Ertapenem antibiotic injection. LPN #202 stated she put the orders in the computer and signed off the medication but did not actually administer the antibiotic medication as ordered. She stated the IV fluids were for Resident #116. She stated she was terminated for the medication error.</p> <p>Interview on 05/13/24 at 9:51 A.M. with NP #803 indicated he gave a verbal order to LPN #202 for the Ertapenem IM antibiotic, the one liter of NS IV fluids and the additional PEG flush for Resident #116. NP #803 stated LPN #202 was having difficulty understanding what he said so he texted her the information for Resident #116 on her personal cellular phone. He stated he did not normally text the information, but the nurse could not spell the antibiotic he wanted for Resident #116's increased white blood cell count. NP #803 confirmed Resident #115 did receive the Ertapenem antibiotic injection in error but the resident did not receive the fluids since the on-call team caught the error when the nurse tried to get an IV team to initiate an intravenous access line for Resident #115. They determined the orders were actually for Resident #116.</p> <p>Review of the Medication Administration policy dated 11/2017 revealed medications were administered by licensed nurses, or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153079.</p>		