

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 07/11/2024
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** 48567</p> <p>Based on observation, interview, review of the facility admission agreement, and review of the facility policy, the facility failed to ensure privacy and dignity were maintained during incontinence care for Resident #12. This affected one resident (#12) of four residents who were reviewed for incontinence care. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure, anoxic brain damage, morbid obesity, dysphagia, sleep apnea, major depressive disorder, and cognitive communication deficit.</p> <p>Review of the annual Minimum Data Set (MDS) 3.0 assessment revealed Resident #12 had severely impaired cognition and was always incontinent of bowel and bladder. Further review of the MDS revealed Resident #12 was dependent on staff for all activities of daily living, including bathing and toileting hygiene.</p> <p>Review of the care plan dated 04/15/24 revealed Resident #12 was totally dependent on staff for all aspects of activities of daily living, including bed mobility, toileting, and personal hygiene. Further review of the care plan revealed Resident #12 experienced bowel and bladder incontinence with interventions including providing incontinence care or perineal care every two hours and as needed for incontinent episodes.</p> <p>Observation of incontinence care on 07/10/24 from 2:15 P.M. to 2:25 P.M. rendered by State tested Nurse Aide (STNA) #401 and STNA #428 revealed Resident #12 received incontinence care in front of a large window alongside a parking lot with cars parked in the lot at eye-level and a person noted sitting inside a vehicle (facing the opposite direction) that was backed-in just outside of Resident #12's window.</p> <p>Interview on 07/10/24 at 2:25 P.M. with STNA #401 confirmed the blinds to the window were open and there were cars in the parking lot outside Resident #12's window while she was receiving incontinence care.</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>Interview with STNA #428 confirmed she always made sure to shut resident doors and use privacy curtains when rendering any personal care but had not thought about the window blinds needing shut for privacy.</p> <p>Review of the admission packet titled Embassy Healthcare Admission Agreement revealed each resident had the right to be treated in a dignified manner.</p> <p>Review of the policy titled Perineal Care, dated 11/10/22, revealed staff were to provide for resident privacy prior to performing incontinence care.</p> <p>This deficiency was an incidental finding identified during the complaint investigation.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567</p> <p>Based on interview, medical record review, and facility policy review, the facility failed to ensure medications were administered per physician orders for Resident #46. This affected one resident (#46) out of four who were reviewed for medication administration. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, history of urinary tract infections, spinal stenosis of the lumbar region, depression, fibromyalgia, disorders of the diaphragm, bronchiectasis, and dysphagia.</p> <p>Review of the admission Minimum Data Set (MDS) assessment revealed Resident #46 had intact cognition. Further review of the MDS revealed Resident #46 required oxygen therapy and non-invasive mechanical ventilation.</p> <p>Review of the care plan dated 06/08/24 revealed Resident #46 had altered respiratory status related to chronic obstructive pulmonary disease (COPD), respiratory failure, bronchiectasis, and disorders of the diaphragm. Interventions included the administration of aerosols and/or bronchodilators as ordered. Further review of the care plan revealed Resident #46 had a genitourinary impairment and history of frequent urinary tract infections (UTIs). Interventions included the administration of medications per physician orders. Review of the care plan also revealed Resident #46 had the potential for alteration in comfort with interventions including administering analgesics per physician orders and evaluating effectiveness of pain management interventions.</p> <p>Review of the physician orders revealed an order dated 07/05/24 for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 milligrams (mg) per three milliliters (ml), administer 3 ml by oral inhalation every six hours for shortness of breath beginning 07/05/24 at 6:00 P.M.</p> <p>Further review of the physician orders revealed orders dated 07/02/24 for the following: 1) Premarin vaginal cream 0.625 mg per gram, insert 2 grams vaginally at bedtime for hormones, and 2) Lidocaine external patch 4 percent (%), apply topically to bilateral knees twice daily for pain.</p> <p>Review of the respiratory medication administration record (MAR) for July 2024 revealed no documentation Resident #46 received any doses of the prescribed Ipratropium-Albuterol 0.5-2.5/3ml aerosol treatment on the following dates and times:</p> <p>07/05/24 at 6:00 P.M.</p> <p>07/06/24 at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M.</p> <p>07/07/24 at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M.</p> <p>07/08/24 at 12:00 A.M. and 6:00 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MAR from July 2024 revealed documentation Premarin and Lidocaine were not given as ordered on 07/04/24 with notation to see the nurses notes for detail. Review of the progress notes dated 07/05/25 at 6:01 A.M. noted the Premarin was on order and the Lidocaine patch was on order.</p> <p>Interview on 07/11/24 at 10:45 A.M. with Resident #46 revealed she was concerned that she was not getting her Premarin nightly. She further revealed some nights she would get it, some nights she would not get it at all, and one night, the nurse waited until 6:00 A.M. to give her the Premarin, which she stated was supposed to be given at bedtime. During the interview, Resident #46's daughter also confirmed the Premarin was not given nightly, and she was present the morning it was administered at 6:00 A.M., but she did not recall the exact date. Resident #46 continued to express an additional concern during the interview that she had not been consistently receiving her aerosol treatments and they are supposed to be given routinely every six hours.</p> <p>Interview on 07/11/24 at 3:30 P.M. with Director Respiratory Therapy #413 confirmed he conferred with the pulmonologist and changed Resident #46's Ipratropium-Albuterol order from four time per day to every six hours the afternoon of 07/05/24 and noticed on the afternoon of 07/08/24 that the order was on the respiratory MAR but there was a notation in red ink indicating the order had not been confirmed and was awaiting it to be read back to the ordering provider. He also confirmed the MAR indicated Resident #46 had not received the ordered Ipratropium-Albuterol aerosol treatment from the 6:00 P.M. dose on 07/05/24 until the 6:00 P.M. dose on 07/08/24.</p> <p>Interview on 07/11/24 at 3:45 P.M. with the Director of Nursing (DON) confirmed the Premarin vaginal cream and Lidocaine 4% pain patches were not administered to Resident #46 on the evening of 07/04/24 because they were not available from the pharmacy.</p> <p>Review of the policy titled Medication Administration, dated 08/22/22, revealed medications were to be given as ordered by the physician and in accordance with professional standards of practice.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00155563.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>48567</p> <p>Based on observation, interview, and review of the facility maintenance documents, the facility failed to ensure the building was maintained in a clean, home-like, leak-free environment, or that the building did not have exterior precautions that would prevent insects from coming into the building. This had the potential to affect all 46 residents residing in the facility.</p> <p>Findings include:</p> <p>Observation on 07/10/24 from 3:20 P.M. to 3:40 P.M. of the main dining hall revealed the following:</p> <p>A missing piece of tile just in front of the lip near the exit from the dining hall to the patio.</p> <p>A bucket in the main dining/activity hall one-third full of water collecting drips from the ceiling. The ceiling above the bucket was covered with peeling paint, wet plaster, and wood beams were exposed underneath.</p> <p>Missing ceiling paint/plaster at least a foot in diameter on the vaulted ceiling with exposed wood and a rust-colored water stain running from the exposed area down to the lower beam which contained loose, bubbling paint.</p> <p>Multiple rust-colored stains around the vent grates.</p> <p>Visible cracks in skylights three and four (there were four skylights, numbered one to four from left to right when looking toward the outside of the building). Skylight number three had visibly sealed cracks with some cracks in the corners that did not appear sealed. Skylight four had cracks noted in the upper right-hand corner.</p> <p>The ceiling near the vending machines was bowed, missing paint and plaster, and a portion of the wooden beams and trusses were visible from below. There were stains running several feet along the lower portion of the beam.</p> <p>Observation and interview on 07/10/24 at 3:25 P.M. revealed Resident #35 was struggling to wheel himself out onto the patio through the doors off the main dining hall when the front right and then the back right tires of his wheelchair got temporarily hung-up in the dip caused by missing/broken tile by the lip of the door leading to the porch. During this observation, Resident #35 revealed that many residents with wheelchairs that like to be independent struggle if their wheel goes into the low area caused by the missing tile. During this interview, Resident #35 also confirmed there was bucket in dining area, further stating buckets must be placed when it rains because the ceiling leaks. Resident #35 then pointed to several of the stains in the ceiling, stating, looks great, doesn't it?</p> <p>Interview on 07/10/24 at 3:40 P.M. with Resident #18 confirmed the bucket sitting on the floor next to the table where he was seated and stated that the leak has been happening for a while.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 07/11/24 at 10:00 A.M. revealed a bucket in center of dining/activity area sitting on top of a white sheet. A small amount of water and wet paint and plaster were noted in the bottom of the bucket. At the time of this observation, a piece of the plaster fell from the ceiling beam into the bucket and Resident #18, who was sitting nearby, shook his head and chuckled.</p> <p>Interview on 07/11/24: at 10:10 A.M. with Resident #45 confirmed buckets had historically been placed throughout the facility when it rained, confirmed there was currently a bucket in the middle of the dining hall and encouraged the surveyor to just look up when walking through the facility and it would be obvious there were water problems.</p> <p>Observation and interview with Director of Maintenance #305 on 07/11/24 from 2:40 P.M. to 2:55 P.M revealed the old kitchen in the facility had soiled floors with large stains on the ceiling and floor which remained from a previously repaired leak in the sprinkler system. Further observation revealed mulch and dirt scattered near the back door and the screen door was covered in debris from the outside, including mulch, dirt, lint build-up, and pappi (the white fuzzy seed dispersal substance found in some plants, such as dandelions). Director of Maintenance #305 confirmed the condition of the kitchen floor, ceiling and screen door at the time of this observation. Director of Maintenance #305 further confirmed there was a missing door sweep and door sill causing an opening at least 3/4 inches wide that was large enough to allow entrance of insects or other pests and that the screen door would not prevent entrance of pests due to two large tears and the screen coming out of the door frame. During this tour and interview, Director of Maintenance #305 also confirmed the roof had an active leak and there was paint and plaster actively dropping from the ceiling beam into the bucket, which was placed in the dining hall to catch the leaks and debris falling from the ceiling. Director of Maintenance #305 further confirmed the ceilings in the main dining hall contained multiple water stains, bubbling, peeling, or missing paint and plaster, areas of the ceiling with exposed wooden ceiling beams, bowing of the ceiling near the vending machines that had been present prior to his employment with that facility, and cracks in the third and fourth skylight that he had made several attempts to seal. During the interview, Director of Maintenance #305 confirmed he had made previous notifications of his concern of the condition of the roof and had obtained quotes he forwarded to the corporate office several months prior, but no work had begun to repair the roof.</p> <p>Interview on 07/11/24 at 3:23 P.M. with Housekeeper Aide #374 confirmed he had no knowledge of the old kitchen being cleaned by the housekeeping department.</p> <p>Review of the quotes obtained for roofing and skylight repairs revealed they were obtained on the following dates: 11/10/22, 04/13/23, and 09/18/23. There were no records to review regarding repairs.</p> <p>Interview on 07/11/24 at 4:20 P.M. with Director of Maintenance #305 confirmed it had been over a year, to his knowledge, that the roof of the facility and the skylights had needed repair, there were additional quotes obtained by previous staff, and no roof repairs had been done, other than his attempt to seal cracks in the skylights.</p> <p>Interview on 07/11/24 with the Administrator at 4:25 P.M. confirmed there were no specific policies on building maintenance.</p> <p>(continued on next page)</p>		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the admission packet titled Embassy Healthcare Admission Agreement revealed the facility was to provide a safe, clean, sanitary, comfortable, homelike environment, and ensure housekeeping and maintenance services were provided to maintain the facility in good condition. This deficiency represents non-compliance investigated under Master Complaint Number OH00155563.		