STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365825	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Oaks	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, observation and interview, the facility failed to provide showers for Resident #5 who was dependent on staff for showers and grooming. This affected one resident (Resident #5) out of three residents reviewed for activity of daily living needs. The facility census was 44. Findings include: Review of medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included acute respiratory failure with hypoxia (low levels of oxygen), chronic obstructive pulmonary disease (COPD), hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, mixed receptive -expressive language disorder, dependence on respirator, encounter for attention to tracheostomy, and metabolic encephalopathy. Review of quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/04/24, revealed Resident #5 was severely impaired cognitively, had no rejection of care during the assessment reference period, and was dependent on staff for all activities of daily living and for mobility. Resident #5 was on oxygen therapy, required suctioning, tracheostomy care, and used an invasive mechanical ventilator. Review of Resident #5's care plan, dated 07/06/23, revealed the resident needed assistance for activity of daily living related to cognitive impairment. Interventions included: nail care daily; resident was totally dependent and did not participate in any aspect of the task for shower/bathing; and staff would assist as needed with daily hygiene and would assist with showering residents as per facility policy. Review of facility undated document Skilled Shower and Wheelchair Cleaning Schedule revealed Resident #5 was scheduled to receive showers on Wednesday and Friday day shift, and if a resident refused a shower, a bed bath must be offered. Review of shower sheets from 08/01/24 to 09/16/24 revealed Resident #5 had only received a bed bath or a partial bed bath during that time frame. Interview on 09/17/24 at 9:00 A.M. with Respiratory Therapist (RT) #390 revealed residents with a tracheostomy or ventilator could receive showers if the respiratory status was stable. RT #390 stated Resident #5's respiratory status was stable and could receive showers. (continued on next page)

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/17/24 at 10:21 A.M. of Resident #5's nails with Licensed Practical Nurse (LPN) #351 revealed all five nails on the residents left hand had a build up of a black substance under the nails, and the third nail on her right hand had a buildup of a black substance under her third nail. LPN #351 confirmed the areas of concern at the time of observation. Interview on 09/17/24 at 10:27 A.M. with State tested Nursing Assistant (STNA) #447 confirmed bed baths were only being given to Resident #5. STNA #447 stated the resident had been getting showers in the past but they stopped, and she couldn't remember why. STNA #447 stated Resident #5 liked to scratch and reach for her bottom, and the black buildup could be from her stool. Interview on 09/17/24 at 11:15 A.M. with family of Resident #5 revealed she had a camera in the resident's room, and she could see that the staff were not giving the resident showers. She stated Resident #5 had a habit of digging in her stool, and there was black under her nails. She stated the staff were giving the resident bed baths, but she would prefer the resident get showers instead. Review of facility policy Resident Care, revised 03/29/22, revealed residents would be bathed or assisted to shower or bathe routinely and as needed per their preference. Personal hygiene for a resident would include cleaning of fingernails and toenails. This deficiency represents noncompliance investigated under Complaint Number OH00157814.

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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 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** 30809 Based on observation and interview the facility failed to ensure a medication error rate was less than five percent. Two errors occurred within 22 opportunities for error resulting in a medication error rate of nine percent. This affected two residents (#32 and #40) out of three residents observed for medications administration. The facility census was 44. Findings include: An observation on 09/18/24 between 11:00 A.M. and 3:00 P.M. of three Licensed Practical Nurses (LPN #355, LPN #361, LPN #358) administer medications to three residents (Resident #12, Resident #32, Resident #40) with 22 opportunities for error revealed two medication errors were observed as follows (The medication error rate was 9 percent): 1. Resident #32 was admitted on [DATE] with diagnoses including chronic respiratory, kidney and heart failure with heart arrhythmia, ileus, high cholesterol, obstructive sleep apnea, prostate cancer, spinal stenosis, hypothyroidism, hyponatremia, atherosclerotic heart disease and diabetes mellitus. A review of Resident #32's Medication Administration Record (MAR) indicated to administer the following oral medication upon rising in the morning: Allopurinol 100 milligrams (mg), Amiodarone Hydrochloride 200 mg, Amitryptyline Hydrochloride 10 mg, Cardizem CD capsule extended release 24 hour 240 mg, Cholecalciferol 25 micrograms (mcg), Isosorbide Mononitrate extended release 24 hour 30 mg, Niferex 150 mg, Spironolactone 25 mg, Apixaban 5 mg, Colace 100 mg, Guaifenesin 1200 mg, Mirilax (Polyethylene Glycol) 17 grams (gr), Potassium Chloride Extended Release 10 milliequivalent (mEq), Topiramate 25 mg, Torsemide 40 mg and Acetaminophen 500 mg. An observation on 09/18/24 at 11:11 A.M. of Licensed Practical Nurse (LPN) #355 administer the oral medications listed above to Resident #32 revealed the incorrect dose of Polyethylene Glycol was administered. LPN #355 obtained the jug of Polyethylene Glycol powder and poured the powder in the cap of the jug to approximately three quarters of the way to the top of the cap. LPN #355 poured the polyethylene glycol powder in a drinking cup and added water to dissolve the powder. LPN #355 proceeded to administer the polyehtylene glycol solution to Resident #32 along with the 15 additional oral medications listed above. An interview with LPN #355 at 12:03 P.M. verified the instructions on the Polyehylene Glycol indicated to fill the cap of the jug to the top to administer one 17 gr dose of the Polyehtylene Glycol. LPN #355 verified she did not fill the cap to the top with the Polyehthylene Glycol. 2. Resident #40 was admitted on [DATE] and readmitted on [DATE] with diagnoses inclduing sepsis, hypotension, asthma, dysphagia, rheumatoid arthritis, venous insufficiency, respiratory/heart failure, quadriplegia, anemia, vitamin D deficiency, gastroesophageal reflux disease, depression, neuromuscular bladder, osteoporosis, and systemic lupus erythematosis. A review of Resident #40's MAR dated 09/01/24 to 09/30/24 indicated to administer morphine extended release 30 mg tablet orally two times a day. (continued on next page)

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	365825	A. Building B. Wing	09/18/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of LPN #361 administer morphine 30 mg extended release tablet orally to Resident #40 on 09/18/24 at 1:13 P.M. revealed concerns with the preparation of the medication. LPN #361 obtained the medication from the medication cart and proceeded to crush the medication and placed the crushed medication in a medications cup with applesauce. LPN #361 proceeded to enter Resident #40's room and administered the crushed morphine/apple sauce mixture to Resident #40. An interview with LPN #361 at 1:22 P.M. verified he had crushed the morphine medication and there was no physician order to crush the morphine tablet. The facility policy titled Medication Administration Policy 5.3.14 Crushing Medications effective date 06/21/17 indicated all medications which do not lose effectiveness, or produce side effects when crushed , may be crushed per prescriber's order for residents who have difficulty swallowing medications. The procedure indicated the crushing of medications requires a prescriber's order. Medications which have an enteric coating, extended release, sublingual or otherwise noted by the manufacturer as inappropriate for crushing, may not be crushed. If crushing of the medication is authorized by the physician, the Pharmacy should be notified and documentation must be made in the resident's medical record. If the physician orders to crush a do not crush medication, the physician documentation in the resident's chart must indicated that the benefits outweigh the risk of crushing it. This deficiency represents non-compliance investigated under Complaint Number OH00157878.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review and interview the facility failed to ensure Resident #41 received his anticoagulant medication (apixaban) in a timely manner. This affected one resident (#41) out of three residents reviewed for medication administration. The facility census was 44. Findings include: Resident #41 was admitted on [DATE] with diagnoses including interstitial pulmonary disease, chronic respiratory and heart failure, cardiac arrhythmia, vascular dementia, high blood pressure, spinal stenosis, obesity, depression, glaucoma, anxiety, obstructive sleep apnea, idiopathic neuropathy, and anemia. A review of Resident #41's Medication Administration Record (MAR) dated 09/01/24 to 09/30/24 indicated to administer apixaban 5 milligrams (mg) orally two times a day. The apixaban medications was scheduled to be administered at lunch time and nighttime at 7:00 P.M. Resident #41's MAR indicated documentation that the scheduled lunch time dose of apixaban 5 mg was administered orally on 09/15/24 at 5:50 P.M. The next dose was scheduled at 7:00 P.M. on 09/15/24 and administered at 9:17 P.M. A review of Resident #41's clinical record indicated no documentation of the reason for the delay in the scheduled lunch time administration of the apixaban on 09/15/24. An interview with Director of Nursing (DON) on 09/19/24 at 3:50 P.M. indicated that when a medication was scheduled at lunch time the medication should be administered between 11:00 A.M. and 3:00 P.M. The DON verified the above findings at the time of the interview. The DON stated there was no facility policy to address the scheduled medication time frames. The DON provided the guidance for medication administration times titled Grande Oaks Medication Med Pass Times (undated) indicated the lunch scheduled time for staff to administer the medication was from 11:00 A.M. to 3:00 P.M. A review of the apixaban manufacturer information under the pharmacokinetics section 12.3 indicated peak concentration of the apixaban was reached within three to four hours after consumption. Under the section 5. 2 indicated apixaban increases the risk of bleeding and could cause potentially fatal bleeding. This deficiency represents non-compliance investigated under Complaint Number OH00157878.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review, observation and interview the facility failed to date vials of insulin medication after opening. This affected one resident (#32) out of three residents observed for medication administration and had the potential to affect 12 residents (#1, #6, #13, #14, #18, #19, #27, #28, #32, #35, #43, #44). who the facility identified as receiving insulin injections in the facility. The facility census was 44. Findings include: Review of the medical record revealed Resident #32 was admitted on [DATE] with diagnoses including chronic respiratory, kidney and heart failure with heart arrhythmia, ileus, high cholesterol, obstructive sleep apnea, prostate cancer, spinal stenosis, hypothyroidism, hyponatremia, atherosclerotic heart disease and diabetes mellitus. Resident #32's physician order dated 07/19/24 indicated to administer Lispro insulin solution 100 units per milliliter per sliding scale. If the blood glucose level was: 111 milligrams per diluent (mg/dL) to 150 mg/dL administer 0 units, 151 mg/dL to 200 mg/dL administer 2 units, 201 mg/dL to 250 mg/dL administer 4 units, 251 mg/dL to 300 mg/dL administer 6 units, 301 mg/dL to 350 mg/dL administer 8 units, 351 mg/dL to 400 mg/dL administer 10 units. If blood glucose level was greater than 400 mg/dL call the physician. An observation on 09/18/24 at 11:11 A.M. of Licensed Practical Nurse (LPN) #355 administer Resident #32's insulin prior to the lunch meal revealed the multi-dose vial of Lispro insulin was not dated when the vial was opened. LPN #355 verified the multi-dose vial of Lispro insulin had no date when the vial was opened. LPN #355 stated she did not know how long the vial of Lispro insulin could be used before discarding the multi-vial after it was opened. LPN #355 proceeded to use the multi-dose vial of Lispro insulin draw up 4 units of the insulin to treat Resident #32's blood sugar of 237 mg/dL and administered the insulin to Resident #32 subcutaneously. LPN #355 placed the vial of Lispro insulin back in the medication cart. On 09/18/24 at 2:46 P.M. an observation of the two skilled nursing unit medication carts revealed opened multi-dose vials as indicated below: one multi-dose vial of Humalog insulin 100 mg/unit solution one multi-dose vial of Novolog insulin 100 mg/unit solution two multi-dose vials of Humulin R insulin 100 mg/unit solution The above listed multi-dose vials of insulin were not dated when the vials were opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/18/24 between 2:46 P.M. and 3:00 P.M. with LPN #358 and LPN #361 verified the above listed multi-dose vials of insulin were opened and did not have the date the insulin was opened. LPN #361 stated he did not know how long the insulin could be used after opening before it should be discarded. On 09/18/24 at 3:20 P.M. an observation and interview with LPN #355 revealed there were five multi-dose vials of insulin in the two medications carts used for the North/South nursing units in the facility. The following multi-dose vials of insulin were undated: One of two opened multi-dose vials of Lispro One opened multi-dose vial of Humalog Two opened multi-dose vials of insulin The facility policy titled Medication Administration Policy 5.3.9 A Insulin Administration effective date 06/21/17 indicated the procedure item number 6 to follow the manufacturer's instruction for storage and expiration. Ensure that the opened date was documented on the vial or pen. Vials or pens without an open date should be discarded. The facility policy titled Medication Disposal and Returns Policy 6.2 Dating and Discarding of Multi-dose Parenteral Vials effective 06/21/17 indicated nursing staff would date multi-dose vials and discard opened vials as outlined to decrease the risk of contamination and bacterial or fungal growth from multi-dose vials. When initially entering a multi-dose vial, nursing staff should date the vial when first entered. If a multi-dose vial had been opened or accessed the vial should be dated and discarded within 28 days unless the manufacturer recommendation or available literature specified a different date for that opened vial. Nursing staff were responsible for inspecting medications and their expiration date on a regular basis. Expired drugs should be discarded beer policy and procedure. This deficiency represents non-compliance investigated under Complaint Number OH00157878.

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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** 30809 The facility failed to ensure Resident #40's medications were documented at the time the medications were administered. This affected one resident (#40) out of four residents reviewed for medication administration records. The facility census was 44. Findings include: Resident #40 was admitted on [DATE] and readmitted on [DATE] with diagnoses including sepsis, hypotension, asthma, dysphagia, rheumatoid arthritis, venous insufficiency, respiratory/heart failure, quadriplegia, anemia, vitamin D deficiency, gastroesophageal reflux disease, depression, neuromuscular bladder, osteoporosis, and systemic lupus erythematosus. A review of Resident #40's Medication Administration Record (MAR) dated 09/01/24 to 09/30/24 indicated no documentation on 09/16/24 of the medications scheduled as upon rising were administered. The following medications were were scheduled to be administered upon rising: MS Contin 30 milligrams (mg) orally, ProHeal 30 cubic centimeters (cc) orally, Saccharomyces boulardil one capsule orally and Valtrex 1 gram (gr) orally Additional medications not documented as administered on 09/16/24 included: Baclofen 10 mg orally at 2:00 P.M., Gabapentin 600 mg orally at 2:00 P.M., Midodrine hydrochloride 5 mg orally at 2:00 P.M., Oxybutynin chloride 5 mg orally and Acetaminophen 650 mg orally at 12:00 P.M. An interview with Licensed Practical Nurse (LPN) #361 on 09/18/24 at 2:46 P.M. revealed he was assigned to care for Resident #40 on 09/16/24 from 7:00 A.M. to 3:30 P.M. LPN #361 stated Resident #40 often refused to allow the staff to administer her medications at the time they were scheduled. LPN #361 stated the licensed nursing staff would reapproach Resident #361 several times until she agreed to allow consume her medications. LPN #361 verified he did not document Resident #40's medication refusal on the MAR or progress notes during his working shift on 09/16/24. LPN #361 stated LPN #351 took over his assignment at 3:00 P.M. and would have been responsible to administer Resident #40's medications after he had left for the day. An interview with Licensed Practical Nurse (LPN) #351 on 09/18/24 at 3:30 P.M. stated she administered the medications to Resident #40 between 3:00 P.M. and 3:30 P.M. on 09/16/24 but was not sure of the time. LPN #351 stated Resident #40 often refused her medications and the staff reapproached her often to ask her if they could administer her medications later in the day. LPN #351 stated she thought she had documented the medications at the time she administered the medications. A review of the facility policy titled Medication Administration revised on 08/22/22 indicated under the policy explanations and compliance guidelines item number 17 to sign the MAR after administering medication and document medications requiring vital signs on the MAR. Under item number 19 the policy indicated to document any adverse side effects or refusals. This deficiency represents noncompliance as an incidental finding investigated under Complaint Number OH00157878.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review,observation and interview the facility failed to perform proper hand hygiene during medication administration and/or when using the glucometer for Resident #28, #32 and #41 and when providing incontinence care for Resident #41. This affected three residents (#28, #32 and #41) of five residents reviewed for infection control. The facility census was 44. Findings include: 1. Review of the medical record revealed Resident #32 was admitted on [DATE] with diagnoses including chronic respiratory, kidney and heart failure with heart arrhythmia, ileus, high cholesterol, obstructive sleep apnea, prostate cancer, spinal stenosis, hypothyroidism, hyponatremia, atherosclerotic heart disease and diabetes mellitus. An observation on 09/18/24 at 11:11 A.M. of Licensed Practical Nurse (LPN) #355 revealed she had just obtained a resident's blood sugar reading using a glucometer. LPN #355 placed the glucometer in the top drawer of the medication cart and did not disinfect the glucometer. LPN #355 proceeded to obtain Resident #32's blood sugar using the glucometer prior to administering Resident #32's medications. LPN #355 administered Resident #32's medications (Allopurinol 100 milligrams (mg), Amiodarone Hydrochloride 200 mg, Amitriptyline Hydrochloride 10 mg, Cardizem CD capsule extended release 24 hour 240 mg, Cholecalciferol 25 micrograms (mcg), Isosorbide Mononitrate extended release 24 hour 30 mg, Niferex 150 mg, Spironolactone 25 mg, Apixaban 5 mg, Colace 100 mg, Guaifenesin 1200 mg, Mirilax (Polyethylene Glycol) 17 grams (gr), Potassium Chloride Extended Release 10 milliequivalent (mEq), Topiramate 25 mg, Torsemide 40 mg, Acetaminophen 500 mg, aerosol treatment (Budesonide Inhalation Suspension 0.5 mg/2milliliter (ml), topical pain patch (Lidocaine 5 percent patch) and insulin injection (Lispro 100mg/ml per sliding scale) and after completion of the medication administration she failed to perform hand hygiene and failed to clean the glucometer. LPN #355 walked out to her medication cart located next to the nursing station and placed the glucometer on the top of the cart and did not clean it. LPN #355 proceeded to use the glucometer to obtain Resident #28's blood sugar. Upon completion of the observation on 09/18/24 at 12:03 P.M. an interview was conducted with LPN #355 who verified the above findings. 2. Record review for Resident #41 revealed an admitted [DATE] with diagnoses including interstitial pulmonary disease with chronic respiratory failure and heart failure, heart arrhythmia, dysphagia, vascular dementia, high blood pressure, spinal stenosis, and depression. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 09/17/24 at 10:55 A.M. of State tested Nursing Assistant (STNA) #447 assisting Resident #41 with her bowel and bladder incontinence revealed a failure to perform hand hygiene. STNA #447 performed perineal care for Resident #41 changing her gloves six times during the task without performing hand hygiene. STNA #447 proceeded to handle feces/urine soiled linens and incontinence brief and with the same gloved hands proceeded to open Resident #41's chest drawer and obtained a clean incontinence brief. At this time Licensed Practical Nurse (LPN) #351 entered the room to assist STNA #447 with completing the incontinence care task and use a mechanical lift to transfer Resident #41 to her wheelchair. LPN #351 used a gloved hand to apply moisture barrier cream to Resident #41's perineal area and buttocks and then removed her gloves and donned a second pair of gloves without performing hand hygiene. STNA #447 and LPN #351 proceeded to apply Resident #41's incontinence brief , mechanical lift pad and placed clean linens on her bed. STNA #447 and LPN #351 then proceed to use the mechanical lift to transfer Resident #41 to her wheelchair touching various surfaces and equipment in Resident #41's room. An interview on 09/17/24 at 11:30 A.M. with STNA #447 and LPN #351 upon completion of the tasks verified the above finding. A review of the facility policy and procedure titled Hand Hygiene revised 10/01/2022 indicated all staff would perform hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. Hand hygiene should be performed when hands were visibly dirty/soiled, before and after eating, after use of the restroom, after care of a person with infectious diarrhea, when coming on duty, between resident contacts, after handling contaminated objects, before performing invasive procedures, before applying and after removing personal protective equipment including gloves, before preparing and handling of medications, before and after performing resident care procedures, after handling items contaminated with blood, body fluids, secretions/excretions, when moving from a contaminated body site to a clean site while assisting a resident with care, after assistance with personal body functions, after sneezing, coughing and/or blowing nose, before going off duty and when in doubt. This deficiency represents noncompliance as an incidental finding during investigation of Complaint Number OH00157878. This deficiency is an example of continued noncompliance from the survey dated 09/11/24.