| 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 12/02/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grande Oaks | 24579 Broadway Ave<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on record review, policy review and staff interview, the facility failed to implement care planned interventions were followed to complete quarterly smoking safety assessments to ensure safe smoking practices. This affected two (#150, #153) of three residents reviewed for smoking. The facility identified fourteen current residents (#100, #105, #114, #123, #127, #128, #129, #10, #140, #141, #143, #148, #149 and #150) as smokers. The facility census was 49.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #150 revealed and admitted [DATE]. Diagnoses included but were not limited to spastic hemiplegia affecting left nondominant side, epilepsy, and schizoaffective disorder.<br><br>Review of the 09/08/24 quarterly Minimum Data Set (MDS) for Resident #150 revealed he was cognitively intact and was independent for activities of daily living (ADLs).<br><br>Review of the smoking assessment task in the electronic medical record for Resident #150 revealed the last smoking assessment prior to survey entrance was last completed on 02/20/24 which indicated he had loss of upper limbs/paraplegia of upper limbs, smoke two to five times per day and required supervision while smoking.<br><br>Review of care plan for Resident #150 revealed it was last reviewed on 09/26/24. Resident #150 was noted to have potential safety hazard or injury related to smoking. Resident #150 noted to be able to smoke with staff or family supervision. Smoking assessment was to be completed upon admission and quarterly thereafter.<br><br>Interview on 11/18/24 at 2:00 P.M. with the Director of Nursing (DON) confirmed smoking assessments are to be completed quarterly and confirmed the smoking assessments for Residents #150 was not completed quarterly as required.<br><br>2. Review of the closed medical record for Resident #153 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to type II diabetes mellitus, opioid dependence, and bipolar disorder.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365825 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/02/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Grande Oaks | | STREET ADDRESS, CITY, STATE, ZIP CODE: 24579 Broadway Ave, Oakwood Village, OH 44146 | |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of 09/18/24 annual Minimum Data Set (MDS) 3.0 for Resident #153 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Review of activities of daily living (ADLs) revealed resident was independent.<br><br>Review of the care plan for Resident #153 which was last reviewed on 09/14/24 indicated she had potential for safety hazard or injury related to smoking and required supervision by staff or family. Smoking assessments were to be completed upon admission and quarterly thereafter.<br><br>Interview on 11/18/24 at 2:00 P.M. with the DON confirmed smoking assessments are to be completed quarterly and confirmed the smoking assessments for Resident #153 was not completed quarterly as required.<br><br>Review of 12/13/2021 revised facility policy called; Resident Smoking revealed the facility will provide a safe and healthy environment for residents, visitors, and employees including safety as related to smoking. Residents who smoke will be further assessed, and be supervised during smoking times, using the facility policy to determine if safe to smoke at all. The policy did not indicate how frequently smoking assessment would be completed to ensure appropriate safety monitoring of smoking.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159004. |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Plan the resident's discharge to meet the resident's goals and needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on medical record review, psychological evaluation, interview and policy review, the facility failed to ensure Resident #153's mental impairment and resident representative concerns were addressed to ensure a safe discharge for one resident (Resident #153) of three reviewed for discharge. The facility census was 49.<br><br>Findings include:<br><br>Review of the closed medical record for Resident #153 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to type II diabetes mellitus, opioid dependence, and bipolar disorder. Resident #153 was noted to be independent for Activities of Daily Living (ADLs).<br><br>Review of the 03/17/23 Durable Power of Attorney for Healthcare for Resident #153 revealed she listed three power of attorneys (POAs) in order of preference and succession to serve as her agent to make health and personal care decisions. Resident #153's daughter was listed as number one and her son was listed as number three. This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. It was additionally stated that her agent shall act as guardian/conservator or limited guardian/conservator of my person, should guardianship/conservatorship proceedings become necessary or desirable.<br><br>Review of previous social service worker's progress note dated 05/29/24 timed at 7:51 A.M. revealed three notes were left under the social work office door following a leave of absence for Resident #153 with her daughter who is listed as number one of her POAs. Resident #153 expressed her daughter had been mean and wanted to go live with her son in New York and asked the social worker to reach out to her son to go live with him.<br><br>Review of the previous social worker's progress note dated 05/29/24 timed at 7:59 A.M. revealed Resident #153 had intact cognition, and her son was listed on her POA paperwork and agreed to start discharge planning to move Resident #153 to New York.<br><br>Review of social service progress note dated 09/06/24 timed at 10:21 A.M. revealed Resident #153's daughter (listed as POA #1) came to the facility to speak with the Administrator and social worker and was upset about recent communication with Resident #153's son (listed as #3 on POA document). Resident #153's daughter (POA #1) requested social work refrain from contacting any other family member and asked she be the sole point of contact regarding resident's care. POA #1 expressed concern that discharge to New York could result in drug-seeking behavior, harm or even death.<br><br>Review of 09/18/24 annual Minimum Data Set (MDS) 3.0 for Resident #153 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact and was noted to be independent for activities of daily living (ADLs).<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of 09/21/24 physician guardianship evaluation for Resident #153 revealed she was mentally impaired related to diagnosis of bipolar disorder, history of opioid abuse and moderate cognitive impairment. Montreal Cognitive Assessment (MoCA), which is a highly sensitive tool for early detection of mild cognitive impairment, revealed a score of 15 out of 30 which indicated moderate cognitive impairment. Resident #153 was noted to exhibit short term memory difficulty, did not have good insight into her conditions or medications. Licensed Physician Clinical Psychologist #361 recommended a guardian for decision making.<br><br>Review of nursing progress note dated 09/25/24 timed at 3:18 P.M. revealed Resident #153's son (POA #3) came into the facility per resident request to take her home to New York. Resident #153 was educated on risk of going against medical advice (AMA). Paperwork was signed and the ombudsmen and physician were notified Resident #153 was going AMA and medications were sent with resident. Courtesy call was made by the Assistant Director of Nursing (ADON) to POA #1 and informed her Resident #153 had left the facility with POA #3 AMA.<br><br>Review of the 09/25/24 Voluntary Discharge Against Medical Advice (AMA) form signed by Resident #153 and her son (POA #3) revealed Resident #153 chose to go AMA from the facility.<br><br>Phone interview on 10/28/24 at 3:46 P.M. to the complaint department by Resident #153's daughter revealed she had previously met with the social worker (who no longer works at the facility) and learned the facility was facilitating a discharge for Resident #153 and had been communicating with her brother (listed as POA #3). Resident #153's daughter told the social worker had dementia and was not able to safely make decisions. Resident 153's daughter stated the social worker agreed to have a psychological evaluation completed and following the evaluation her mother was indicated as needing a guardian to make decisions. Resident #153's daughter stated she received a call from the facility the day after Resident #153 was discharged telling her that her brother had discharged Resident #153 AMA. Resident #153's daughter stated she was not called prior to the discharge and was not notified until after Resident #153 had left the facility. Resident #153's daughter stated the facility did not call the police.<br><br>Interview on 11/13/24 at 8:15 A.M. with the Director of Nursing (DON) revealed Resident #153 had stated she wanted to go home with her son because she did not want her daughter to be her POA due to a bad relationship and wanted to discharge with her son. DON stated the previous social worker had been in contact with Resident #153's son (POA #3) and he had agreed to take her back to New York with him. Following the physician evaluation on 09/21/24, Resident #153's daughter requested a copy of the evaluation to take it to the court. Resident #153's son came to the facility on [DATE] unannounced to take his mom home with him. The DON told Resident #153 and her son she needed a guardian and called the daughter to tell her that her brother was here to take Resident #153 home with him and her mother was signing AMA papers. The DON stated since Resident #153 had a BIMS of 15 and stated she wanted to leave AMA, the facility had her sign the AMA papers and allowed her to leave with her son (POA #3).<br><br>Phone interview on 11/19/24 at 11:53 A.M. with Psychologist #359 revealed per facility request the psychologist provided an expert evaluation on 09/21/24 and the evaluation results were given to the facility to handle the results and was not reported to the court system.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 11/19/24 at 12:01 P.M. with the Director of Nursing (DON) stated the facility got the expert evaluation on 09/21/24 and confirmed Resident #153's daughter was the first POA listed in the order of succession and preference. The DON also confirmed Resident #153's daughter expressed concerns prior to the discharge regarding not being a safe situation and did not want Resident #153 to discharge with her brother.<br><br>Interview on 11/19/24 at 12:35 P.M. with Regional Nurse #358 confirmed the MoCA revealed cognitive impairment and confirmed it stated Resident #153 would benefit from a guardian. Regional Nurse #358 stated the facility left a message for the Ombudsmen while the son was at the facility on 09/25/24. Regional Nurse #358 confirmed the facility did not contact adult protective services or the police prior to Resident #153 leaving the facility AMA.<br><br>Interview on 11/25/24 at 10:09 A.M. with the DON confirmed she spoke with Resident #153's daughter on 09/25/24 and told her that Resident #153 wanted to discharge with Resident #153's son. DON stated Resident #153's daughter stated it was Resident #153's choice.<br><br>Interview on 11/25/24 at 11:15 P.M. with Nurse Practitioner (NP) #364 stated she was aware Resident #153 had stated she wanted to go to New York with her son (POA #3) but was off during the time Resident #153 discharged . NP #364 stated if she had seen the expert evaluation, she would have gone to management and discussed how to proceed to ensure a safe discharge.<br><br>Follow up interview on 11/25/24 at 12:04 P.M. with NP #364 revealed she had conferred with Physician #365 via electronic text message and confirmed Physician #365 was aware Resident #153 went AMA but was not made aware of the MoCA report completed on 09/21/24 for Resident #153 prior to her discharge on 09/25/24.<br><br>Review of the 09/01/24 revised facility policy called; Transfer and Discharge (including Against Medical Advice (AMA) revealed a resident-initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of resident with cognitive impairment.) For an anticipated transfer or discharge initiated by the resident, supporting documentation shall include evidence of the resident or resident representative's verbal or written notice of intent to the leave the facility, a discharge plan, and documented discussions with the resident and/or resident representative.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159312. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on record review, interviews and policy review, the facility failed to ensure bathing was provided as scheduled for three (Residents #121, #122 and #155) of three residents reviewed for showers. The facility census was 49.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #121 revealed an admitted [DATE]. Diagnoses included but were not limited to chronic respiratory failure, congestive heart failure, dependence upon a respirator, vascular dementia, and obesity.<br><br>Review of 09/14/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #121 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #121 was dependent for bathing and transfers.<br><br>Review of physician orders for Resident #121 revealed an 11/06/24 order for showers every Wednesday and Saturday day shift and to complete a progress notes for all refusals.<br><br>Review of Resident #121's care plan revealed it was last reviewed on 09/13/24 and indicated bathing assistance was required.<br><br>Review of the shower sheets for the past 30 days indicated no evidence of bathing for 10/23/24. Of the eight shower sheets provided six did not have one or both signatures of the nurse and aide. The shower sheet on 10/18/24 indicated a refusal.<br><br>Review of the nursing progress notes did not reflect notation of bathing refusal on 10/18/24.<br><br>Interview on 11/14/24 at 3:26 P.M. with Resident #121's daughter revealed concerns bathing being provided twice weekly consistently.<br><br>Review of the undated facility shower/tub bath/bed bath sheet used to record resident bathing revealed nurse and nursing assistant were to review the shower sheet together. Signatures must be placed in appropriate place.<br><br>Interview on 11/18/24 at 2:00 P.M. with the Director of Nursing (DON) confirmed the Certified Nursing Assistant (CNA) and nurse are to review the shower sheets, confirmed the missing shower sheets for Resident #121.<br><br>Review of the 7/01/2022 facility policy called; Resident Showers revealed residents will be provided with showers as per request or as per facility schedule protocols and based on resident safety. Document that the shower/bath was provided.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the 12/01/22 revised facility policy called; Weight Monitoring revealed interventions will be identified, implemented, monitored (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. A weight monitoring schedule will be developed upon admission for all residents. Other conditions may require weight to be obtained and monitored more frequently; physicians order will determine the frequency.<br><br>2. Review of the medical record for Resident #122 revealed an admitted [DATE]. Diagnoses included but were not limited to acute postprocedural respiratory failure, hemiplegia, dependence on respirator, type II diabetes mellitus, and moderate protein calorie malnutrition.<br><br>Review of the 10/02/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #122 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) revealed resident was dependent for bathing.<br><br>Review of Resident #122's care plan revealed it was last reviewed on 10/19/24 and indicated she was dependent for bathing and prefers a bed bath.<br><br>Review of shower sheets for Resident #122 for the past 30 days revealed no evidence of bathing for 11/01/24 and 11/08/24. Of the eight shower sheets provided for Resident #122, four were missing nurse signatures.<br><br>Review of nursing progress notes for Resident #122 did not reveal any documentation of refusal of bathing for 11/01/24 or 11/08/24.<br><br>Interview on 11/12/24 at 12:03 P.M. with Resident #122 revealed she usually prefers bed baths and sometimes bathing is not completed on her scheduled day.<br><br>Review of the undated facility shower/tub bath/bed bath sheet used to record resident bathing revealed nurse and nursing assistant were to review the shower sheet together. Signatures must be placed in appropriate place.<br><br>Interview on 11/18/24 at 2:00 P.M. with the DON confirmed the CNA and nurse are to review the shower sheets, confirmed the missing shower sheets for Resident #122.<br><br>Review of the 7/01/2022 facility policy called; Resident Showers revealed residents will be provided with showers as per request or as per facility schedule protocols and based on resident safety. Document that the shower/bath was provided.<br><br>Review of the 12/01/22 revised facility policy called; Weight Monitoring revealed interventions will be identified, implemented, monitored (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. A weight monitoring schedule will be developed upon admission for all residents. Other conditions may require weight to be obtained and monitored more frequently; physicians order will determine the frequency.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Review of the closed medical record for Resident #155 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to hypertensive urgency, unspecified severe protein-calorie malnutrition, prostate cancer and stage IV chronic kidney disease.<br><br>Review of 11/03/24 discharge Minimum Data Set (MDS) 3.0 indicated Resident #155 had moderate cognitive impairment. Review of activities of daily living (ADLs) revealed Resident #155 was dependent upon staff for bathing.<br><br>Review of Resident #155's care plan revealed it was last reviewed on 10/08/24 and stated staff assistance was required for bathing.<br><br>Review of the shower sheets for Resident #155 revealed no shower sheet was provided for 10/29/24. Six of the seven shower sheets provided were missing the nurse signature.<br><br>Review of the undated facility shower/tub bath/bed bath sheet used to record resident bathing revealed nurse and nursing assistant were to review the shower sheet together. Signatures must be placed in appropriate place.<br><br>Interview on 11/18/24 at 2:00 P.M. with the DON confirmed the CNA and nurse are to review the shower sheets, confirmed the missing shower sheets for Resident #155.<br><br>Review of the 7/01/2022 facility policy called; Resident Showers revealed residents will be provided with showers as per request or as per facility schedule protocols and based on resident safety. Document that the shower/bath was provided.<br><br>Review of the 12/01/22 revised facility policy called; Weight Monitoring revealed interventions will be identified, implemented, monitored (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. A weight monitoring schedule will be developed upon admission for all residents. Other conditions may require weight to be obtained and monitored more frequently; physicians order will determine the frequency.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159004. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on record review, interviews and policy review, the facility failed to ensure weights were completed per physician ordered related to Resident #121's congestive heart failure. This affected one resident (Resident #121) of three residents reviewed for weight monitoring. The facility census was 49.<br><br>Findings include:<br><br>Review of the medical record for Resident #121 revealed an admitted [DATE]. Diagnoses included but were not limited to chronic respiratory failure, congestive heart failure, dependence upon a respirator, vascular dementia, and obesity.<br><br>Review of 09/14/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #121 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #121 was dependent for transfers.<br><br>Review of physician orders for Resident #121 revealed a 07/03/24 order for daily weights in the morning related to congestive heart failure.<br><br>Review of Resident #121's care plan revealed Resident #121 was noted to be at risk for alteration in nutrition and/or hydration related to obesity, body mass index. Intervention was to monitor weight as physician ordered.<br><br>Review of daily weights for Resident #121 revealed no weights were recorded for 10/03/24, 10/04/24, 10/07/24, 10/08/24, 10/09/24, 10/18/24, 10/20/24, 10/22/24, 10/24/24, 10/30/24, 11/01/24, 11/07/24, 11/08/24, 11/09/24, 11/10/24, 11/16/24 as physician ordered.<br><br>Interview on 11/14/24 at 3:26 P.M. with Resident #121's daughter revealed concerns with daily weights being completed as ordered.<br><br>Interview on 11/18/24 at 2:00 P.M. with the Director of Nursing (DON) confirmed daily weights were not being completed as physician ordered for Resident #121.<br><br>Interview on 11/19/24 at 1:03 P.M. with Dietitian #267 confirmed daily weights were not completed daily as physician ordered for Resident #121.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159004. |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063<br><br>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.<br><br>Based on record review, interviews, review of hospital records, review of witness statements and wound policy, the facility failed to implement an adequate and effective pressure ulcer prevention program to promote healing and to ensure Resident #154, who was cognitively impaired, dependent on staff for activity of daily living care and incontinent of bowel, received left lateral ankle and foot wound treatments timely when dressings had become saturated with fecal material.<br><br>Actual Harm occurred on 10/14/24 when nursing staff failed to change Resident #154's dressing to his left lateral ankle and left lateral foot Stage IV pressure ulcers (full-thickness tissue loss with exposed bone, tendon, or muscle) when Certified Nursing Assistant (CNA) #232 notified Licensed Practical Nurse (LPN) #291 the dressings to the areas were saturated with fecal material. This lack of timely and proper wound care resulted in the ulcers deteriorating and contributed to the development of sepsis and osteomyelitis (infection in the bone requiring intravenous antibiotics) and hospitalization in the intensive care unit. This affected one resident (#154) of three residents reviewed for pressure ulcers. The facility census was 49.<br><br>Findings include:<br><br>Review of the closed medical record for Resident #154 revealed an admitted [DATE] with diagnoses including osteomyelitis (infection in the bone), hypertension, contracture of the right knee and dementia.<br><br>Review of the care plan dated 04/04/24 for Resident #154 revealed he had an actual area of skin impairment, Stage IV pressure wound, to the left lateral ankle and foot. Staff were to continue treatments as ordered by the physician and observe for signs of infection or worsening of the wound.<br><br>Review of the physician's orders and Treatment Administration Record for October 2024 revealed Resident #154 had a treatment dated 10/01/24 to cleanse the left lateral foot with normal saline, pat dry, apply oil emulsion to the wound, cover with an abdominal (ABD) pad and wrap with kerlix daily and as needed. He also had had a treatment (initiated 09/24/24) to cleanse the left lateral ankle with normal saline, pat dry, apply oil emulsion and cover with ABD pad and wrap with kerlix every day on day shift. There was an order to change the left lateral ankle as needed as well. The daily dressing orders were documented as completed on 10/13/24 and 10/14/24 but the as needed orders were not utilized on those dates.<br><br>Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #154 had impaired cognition. The assessment revealed the resident was dependent on staff for activities of daily living including toileting, hygiene and repositioning in bed and the resident was always incontinent of bowel.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Grande Oaks | | STREET ADDRESS, CITY, STATE, ZIP CODE 24579 Broadway Ave Oakwood Village, OH 44146 | |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the wound evaluation and management summary dated 10/07/24 by Wound Physician #360 revealed Resident #154 had a Stage IV pressure wound to the left lateral ankle and left lateral foot. The left lateral ankle Stage IV pressure ulcer measured 2.6 centimeters (cm) length by 2.4 cm width with 0.1 cm depth. There was light serosanguineous (thin clear/pink fluid) drainage with 10 percent (%) slough (dead tissue in wound) and 90% granulation tissue (new tissue). The left lateral foot Stage IV pressure area measured 2.4 cm by 2.3 cm by 0.2 cm. It had moderate serous (thin, watery clear) drainage with 100% granulation tissue. The facility was to continue the dressing changes once daily and off-load the wounds.<br><br>Review of the wound evaluation and management summary dated 10/14/24 by Wound Physician #360 revealed Resident #154 still had Stage IV pressure wounds to the left lateral ankle and left lateral foot and the wounds had deteriorated. The left lateral ankle Stage IV pressure ulcer measured 7 cm by 5 cm by 0.3 cm and had exacerbated due to infection. There was moderate serous drainage with only 60% granulation tissue noted with 30% other viable tissues observed which included bone, fascia, tendon and muscle. Wound Physician #360 stated the wound was highly suspicious for osteomyelitis and she would start intravenous antibiotics pending the wound culture. The left lateral foot Stage IV pressure ulcer measured 3 cm by 3 cm by 0.2 cm. There was 80% granulation tissue and 20% slough. There was moderate serous drainage noted. The wound progress was noted to be exacerbated due to multifactorial (meaning the wound of the left lateral ankle). Wound Physician #360 ordered laboratory values, wound culture, x-ray and two intravenous antibiotics.<br><br>Review of the nursing progress note dated 10/14/24 at 5:39 P.M. revealed Resident #154 was transferred to a skilled room for antibiotic intravenous therapy related to a wound infection. On 10/14/24 at 6:27 P.M. Resident #154 had a peripherally inserted central catheter line placed to his left arm for intravenous antibiotics. On 10/15/24 at 7:00 P.M. Resident #154 had a dressing change to his left leg and there was noted to be plus two pitting edema to the knee and it was warm to the touch. Vital signs were obtained and were noted to be abnormal with his blood pressure at 103/57 (normal 120/80), pulse of 121 (normal 60-100), respirations of 22 (normal 12-20) and temperature of 99.9 degrees Fahrenheit (normal 98.6). The physician was updated and a new order was given to send him to the emergency department. On 10/16/24 at 1:09 A. M. it was noted that Resident #154 was admitted to the hospital for septic shock.<br><br>Review of the left ankle x-ray dated 10/14/24 revealed changes associated with prior osteomyelitis involving the distal fibula. Acute osteomyelitis was not excluded. The impression stated if there was exposed bone, then acute osteomyelitis was presumed.<br><br>Review of the critical care consult note from the hospital records dated 10/16/24 revealed Resident #154 was at the hospital due to left lower leg swelling. During his stay at the hospital it was noted he had sepsis due to osteomyelitis and possible abscess to his left lower extremity.<br><br>Review of a disciplinary action form dated 10/17/24 for LPN #291 revealed the LPN was given a written and final warning due to not providing the necessary care to a resident to prevent further breakdown in a wound.<br><br>Review of the facility investigation revealed a statement dated 10/17/24 by CNA #232 stating Resident #154 had a large bowel movement and she had informed the nurse on duty that his dressing was soiled. She provided care for him and changed his bedding and covered his left foot and dressing with a sheet to protect the new sheets until the nurse came to perform the dressing change.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 11/21/24 at 9:16 A.M. with LPN #206 revealed Resident #154 had contractures to the bilateral lower legs and had many skin impairments throughout his stay. She stated the nursing staff were able to resolve many of these areas, but he had chronic wounds. She stated on 10/14/24 at 12:00 P.M. she was performing wound rounds with Wound Physician #360 to Resident #154. She stated his left lateral foot and ankle dressings were saturated. She stated the dressing was removed and Wound Physician #360 was upset the dressings were contaminated with feces and had not been changed. She stated it was suspected he had a wound infection, and the physician ordered antibiotics, an x-ray, wound culture and laboratory tests. LPN #206 stated she immediately started an investigation which revealed Resident #154's dressings had become saturated with feces on 10/14/24 at 3:00 A.M. She stated CNA #232 had updated LPN #291 the dressings were saturated and needed changed. LPN #206 stated LPN #291 admitted she had gotten busy and forgot to change the dressing. The next dressing changes were on dayshift on 10/14/24 and were not changed until the physician had performed wound rounds. LPN #206 stated she had interviewed the nursing staff who had worked on 10/11/24, 10/12/24 and 10/13/24, who all stated the wounds had no signs or symptoms of infection and the dressings were changed as ordered.<br><br>Interview on 11/21/24 at 12:50 P.M. with Wound Physician #360 revealed Resident #154's wound deteriorated between 10/07/24 and 10/14/24. She stated when she assessed the resident on 10/14/24 at 12:00 P.M. his left lateral ankle and foot dressings were soiled with feces and were contaminated. She stated upon assessment, the Stage IV pressure ulcers had increased in size and she suspected there was an infection. Wound Physician #360 stated she ordered an x-ray to rule out osteomyelitis, obtained a wound culture, ordered laboratory tests and started two intravenous antibiotics.<br><br>Attempted phone interviews with CNA #232 and LPN #291 on 11/21/24 and 11/25/24 were unsuccessful. Voicemail messages were left with no return contact made.<br><br>Review of the facility policy titled, Wound Treatment Management, dated 12/01/21, stated wound treatments would be provided in accordance with the physician's orders. The policy stated dressing changes may be provided if feces had seeped underneath the dressing or the dressing was soiled.<br><br>The deficient practice was corrected on 10/18/24 when the facility implemented the following corrective actions:<br><br>On 10/16/24 and 10/17/24 DON and LPN #206 provided nursing staff education on the facility policy titled, Wound Treatment Management, dated 12/01/21, including changing the dressing if feces had seeped underneath the dressing or the dressing was soiled as well as adding an order for all residents with wounds to check the integrity of the dressing each shift and replace if needed.<br><br>On 10/17/24 by LPN #206 completed wound and dressing audits for all residents to ensure dressings were intact and the orders were correct without negative findings.<br><br>On 10/17/24 the Administrator provided LPN #291 education and disciplinary action.<br><br>On 10/18/24 audits were initiated of wound dressing observations including if the dressing was clean, dry and intact as well as if the order was in place to check the integrity of the dressing each shift. These audits were to be completed by the DON or her designed three times a week for one week and then weekly thereafter for three weeks. The results would be taken to the quality assurance meetings.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | This deficiency represents non-compliance investigation under Complaint Number OH00159247. |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the resident and his/her doctor meet face-to-face at all required visits.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on medical record review, interview and facility policy the facility failed to ensure physician visits were completed as required. This affected three of three residents (Residents #122, #153 and #154) reviewed for physician services. This had the potential to affect all 49 residents residing at the facility.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #122 revealed an admitted [DATE]. Diagnoses included but were not limited to acute postprocedural respiratory failure, hemiplegia, dependence on respirator, type II diabetes mellitus, and moderate protein calorie malnutrition.<br><br>Review of 10/02/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #122 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition and dependence upon staff for activities of daily living (ADLs).<br><br>Review of the physician visits for Resident #122 revealed no physician or nurse practitioner visits since 09/05/24. Physician visits listed within the past year were 11/07/23, 08/16/24 and 09/05/24. No nurse practitioner notes were listed in the progress notes or under the miscellaneous tab under tab.<br><br>Interview on 11/14/24 at 8:32 A.M. with the Director or Nursing (DON) confirmed there were not monthly alternating physician and nurse practitioner visits for Residents #122.<br><br>2. Review of the closed medical record for Resident #153 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to type II diabetes mellitus, opioid dependence, and bipolar disorder.<br><br>Review of the 09/18/24 annual Minimum Data Set (MDS) 3.0 for Resident #153 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition.<br><br>Review of physician visits for Resident #153 revealed the physician visits were listed as 04/08/24, 05/15/24, and 06/17/24. Nurse Practitioner visits were listed at least monthly on 11/03/23, 12/11/23, 12/18/23, 01/05/24, 01/31/24, 02/02/24, 2/14/24, 02/24/24, 03/04/24, 03/27/24, 04/21/24, 05/03/24, 06/27/24, 07/12/24, 07/31/24, 08/05/24, 08/27/24, 09/18/24, 09/23/24, Visits were not alternated with the physician as required. There was no evidence of a physician visit between 06/17/24 and 09/25/24 at discharge.<br><br>Interview on 11/14/24 at 8:32 A.M. with the DON confirmed there were not monthly alternating physician and nurse practitioner visits for Residents #153.<br><br>3. Review of the medical record for Resident #154 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to atherosclerotic heart disease of native coronary artery, hyperlipidemia, unspecified dementia, mild protein-calorie malnutrition, epilepsy, and prostate cancer.<br><br>(continued on next page) |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of 10/15/24 discharge Minimum Data Set (MDS) 3.0 revealed moderate cognitive impairment.<br><br>Review of the physician visits for Resident #154 revealed the only physician visits listed were on 07/26/24 and 08/16/24. No nurse practitioner visit notes were found under the nursing progress notes or miscellaneous sections of the medical record.<br><br>Interview on 11/14/24 at 8:32 A.M. with the DON confirmed there were not monthly alternating physician and nurse practitioner visits for Residents #154.<br><br>Review of the 06/01/24 revised facility policy called; Physician Visits and Physician Delegation revealed at the option of the physician, required visits in the SNF (skilled nursing facility), after the initial visit, may alternate between personal visits by the physician and visits by a physician, assistant, nurse practitioner, or clinical nurse specialist that is acting within scope of practice defined by State law and under the supervision of the physician.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00150368. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>43063<br><br>Based on record review and interview, the facility failed to use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 49 residents residing in the facility.<br><br>Findings include:<br><br>Review of the facility staffing schedules and the staff punch details dated from 10/01/24 through 10/31/24, revealed there was no RN coverage for 10/27/24.<br><br>Interview on 11/21/24 at 11:58 A.M. with Human Resources Director #287 verified there was no RN coverage on 10/27/24.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159004. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063<br><br>Based on record review and interviews, the facility failed to ensure Resident #155 was free of significant medication errors. This affected one (Resident #155) of six residents reviewed for medication errors. The facility census was 49.<br><br>Findings include:<br><br>Review of the closed medical record for Resident #155 revealed an admitted [DATE] with diagnoses including chronic kidney disease, heart failure and sepsis. He was discharged to the hospital on 11/04/24 for gastrointestinal bleeding.<br><br>Review of Resident #155's census at the facility revealed he was active in the facility from 10/07/24 through 10/28/24.<br><br>Review of the physician's orders for Resident #155 revealed he was on antibiotics for an urinary tract infection and wound infection. His orders included:<br><br>-Ceftriaxone Sodium Intravenous Solution 2 grams (antibiotic) at lunch dated 10/08/24 and discontinued 10/09/24.<br><br>-Ceftriaxone Sodium Intravenous Solution 2 grams at lunch dated 10/09/24 and discontinued 10/14/24.<br><br>-Ceftriaxone Sodium Intravenous Solution 2 grams at lunch dated 10/15/24 and discontinued 10/30/24.<br><br>-Ampicillin Sodium Intravenous Solution 2 grams (antibiotic) upon rising and at bedtime dated 10/09/24 and discontinued 10/12/24.<br><br>-Ampicillin Sodium Intravenous Solution 2 grams upon rising and at bedtime dated 10/13/24 and discontinued 10/30/24.<br><br>-Heparin Sodium Lock Flush Intravenous Solution 5 milliliters (mL) three times a day for flush before and after antibiotic and as needed dated 10/08/24 and discontinued 10/24/24.<br><br>Review of the Medication Administration Record (MAR) for October 2024 revealed intravenous medications were not administered per the physician's orders. Ceftriaxone was not administered on 10/08/24, 10/14/24 and 10/17/24; Ampicillin was not administered on 10/09/24, 10/11/24, 10/12/24, 10/15/24, 10/16/24, 10/17/24, 10/19/24, 10/22/24, 10/26/24 and 10/27/24 at bedtime; Ampicillin was not administered upon rising on 10/12/24 and 10/14/24; Heparin Sodium flush was not administered at 2:00 P.M. on 10/08/24, 10/14/24 and 10/17/24; at 10:00 P.M. on 10/08/24, 10/09/24, 10/11/24, 10/12/24, 10/13/24, 10/14/24, 10/15/24, 10/16/24, 10/17/24, 10/18/24, 10/19/24 and 10/22/24; and at 6:00 A.M. on 10/09/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/14/24, 10/15/24, 10/16/24, 10/17/24, 10/18/24, 10/19/24, 10/20/24, 10/23/24 and 10/24/24.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the nursing progress notes revealed Heparin Sodium flush was not administered on 10/15/24 at 10:25 P.M., 10/16/24 at 6:34 A.M., 10/17/24 at 6:34 A.M. and 10/18/24 at 9:16 P.M. due to a Registered Nurse (RN) not being available. On 10/16/24 at 8:51 P.M. the progress note revealed Ampicillin Sodium Intravenous Solution was not given due to an RN not being available.<br><br>Interview on 11/19/24 at 12:44 P.M. with Regional RN #358 verified Resident #155's intravenous antibiotics as well as his Heparin flushes were not administered as ordered and documented for the dates listed above.<br><br>Interview on 11/21/24 at 8:30 A.M. with Licensed Practical Nurse (LPN) #293 verified Resident #155 missed intravenous antibiotics and Heparin flushes because there was not an RN available to administer.<br><br>Interview on 11/21/24 at 9:05 A.M. with an anonymous staff member verified there were no RN's who worked on midnights. She stated if the facility had a dayshift RN, they would stay and administer intravenous medications to Resident #155. The staff member stated Resident #154 had a central line and this was not under the scope of practice as a LPN. The staff member stated there were days Resident #154 missed his intravenous medications as there was not an RN available. They stated nursing management was aware there was no RN to administer these medications.<br><br>Review of the facility policy titled, Medication Administration, dated 08/22/22, revealed medications were to be administered as ordered by the physician.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159247 and OH00159004. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>45442<br><br>Based on observation, interview and review of facility policy, the facility failed to serve meals at a palatable temperature. This had the potential to affect 41 residents who received food from the kitchen. The facility identified eight residents (Residents #107, #110, #113, #115, #116, #117, #119, and #152) who received nothing by mouth. The facility census was 49.<br><br>Findings include:<br><br>Review of the facility posted meal times revealed breakfast is served at 8:30 A.M., lunch is served at 12:30 P. M. and dinner is served at 5:00 P.M.<br><br>Observation on 11/12/24 at 10:00 A.M. with Dietary Manager (DM) #266 revealed there were no lunch temperatures for 10/18/24 no lunch and dinner temperatures taken on 11/07/24, no dinner temperatures for 10/2/24, 10/03/24, 10/05/24, 10/06/24, 10/07/24, 10/11/24, 10/12/24, 10/15/24, 10/17/24, 10/18/24, 10/23/24, 10/24/24, 10/30/24 and 10/31/24, 11/02/24, 11/03/24, 11/06/24, 11/08/24, 11/10/24 and no evidence of temperatures taken for breakfast, lunch or dinner on 10/28/24, 10/29/24 and 11/11/24.<br><br>Observation of lunch tray line temperatures on 11/12/24 at 12:18 P.M. with [NAME] #253 revealed appropriate temperatures for the listed menu items. Temperatures were as follows: Beef and Broccoli 195 F, Mechanical Soft Beef 169 F, Pureed Beef and Broccoli 168 F, [NAME] and wild rice 197 F, Parslied Carrots 190 F, Pureed Carrots 165 F, Pureed Rice 165 F, Gravy 171 F, Pureed Bread 118 F. Tray line started at 12:20 P.M. which ran until 12:40 P.M. for the adjacent facility which had a separate license. Tray line started at 12:40 P.M. and stopped at 1:14 P.M. due to running out of the white and wild rice. Five trays (Resident #147, #148, #149, #150 and #151) were left to finish. [NAME] # 253 confirmed due to running out of rice, the last five trays were delayed while more rice was made.<br><br>Observation on 11/12/24 at 1:23 P.M. tray line resumed and finished at 1:25 P.M. Last food service cart arrived to the south hall at 1:28 P.M. Tray pass was initiated and finished at 1:40 P.M. Test tray was removed from the cart and test tray was completed with DM #266 at 1:42 P.M. Beef and Broccoli with rice was 168 F, Carrots were 112 F, Pureed Rice was 133 F, Pureed Bread was 121. Following the tasting of the lunch test tray, DM #266 confirmed the tray was later than 45 minutes past the posted delivery time, the carrots were not warm enough and the pureed rice was not the appropriate consistency.<br><br>Interview on 11/13/24 at 12:08 P.M. with Resident #149 stated sometimes meals are late and are not warm enough.<br><br>Review of the 12/10/22 facility policy called; Test Tray and Point of Service Food Temperatures revealed food should be served palatable, attractive and at an appetizing temperature.<br><br>Review of the October 2017 revised facility policy called; Food and Nutrition Services revealed meals will be provided within 45 minutes of either resident request or scheduled mealtime and in accordance with the resident's medical requirements. Nourishing snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snack may be scheduled between meals to accommodate the resident's typical eating patterns.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grande Oaks | 24579 Broadway Ave<br>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 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | This deficiency represents non-compliance investigated under Complaint Number OH00159247. |

| 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 12/02/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Grande Oaks | | STREET ADDRESS, CITY, STATE, ZIP CODE 24579 Broadway Ave Oakwood Village, OH 44146 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on interview, observation and policy review the facility failed to ensure physician ordered diet modified texture was followed as required. This affected one (Resident #122) of three reviewed for diet texture. The facility census was 49.<br><br>Findings include:<br><br>Review of the medical record for Resident #122 revealed an admitted [DATE]. Diagnoses included but are not limited to acute postprocedural respiratory failure, hemiplegia, dependence on respirator, type II diabetes mellitus, and moderate protein calorie malnutrition.<br><br>Review of 10/02/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #122 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) revealed resident received a mechanically altered diet and required set up for eating meals.<br><br>Review of the care plan for Resident #122 which was last reviewed on 10/19/24 revealed risk for dental or chewing problems related to missing or broken teeth. Interventions was diet as ordered by the physician.<br><br>Review of the physician orders dated 10/17/23 for Resident #122 revealed a diet order for regular no added salt double portions with pureed texture with thin liquids.<br><br>Interview on 11/12/24 at 12:03 P.M. with Resident #122 revealed she did not have concerns related to her pureed meal trays.<br><br>Observation on 11/12/24 at 1:42 P.M. of the test tray revealed the pureed rice which did not appear to be a smooth consistency and appeared to have visible rice particles. Interview following test tray with Dietary Manager #266 confirmed the pureed rice did not appear to have a smooth consistency and upon tasting was not a smooth pureed texture as required.<br><br>Review of the 2008 facility policy called; Dysphagia Puree (Level 1) Diet revealed all foods are purred to simulate a soft food bolus, elimination the whole chewing phase. All foods must be the consistency of moist mashed potatoes or pudding.<br><br>This violation represents non-compliance investigated under Complaint Number OH00159247. |

| 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 12/02/2024 |
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| NAME OF PROVIDER OR SUPPLIER Grande Oaks | | STREET ADDRESS, CITY, STATE, ZIP CODE 24579 Broadway Ave Oakwood Village, OH 44146 | |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on observation, interview and review of facility policy the facility failed to ensure adequate hydration was provided between meals as required. This affected four residents (Resident #121, #122, #125, and #137) and had the potential to affect 41 residents who received food from the kitchen. The facility identified eight residents (Residents #107, #110, #113, #115, #116, #117, #119, and #152) who received nothing by mouth.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #121 revealed an admitted [DATE]. Diagnoses included but were not limited to chronic respiratory failure, dependence upon a respirator, vascular dementia, and obesity.<br><br>Review of 09/14/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #121 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated resident was cognitively intact. Review of activities of daily living (ADLs) revealed resident requires supervision with eating and drinking.<br><br>Review of Resident #121's care plan which was last reviewed on 09/13/24 revealed she was at risk for alteration in nutrition and/or hydration related to obesity, body mass index, and tendency to become short of breath during meals and use of diuretics. Interventions were to monitor for signs and symptoms of dehydration (poor skin turgor, dry mucous membranes, decreased urine output, change in mental status). Document observation and interventions as needed.<br><br>Review of the electronic medical record under the hydration task for Resident #121 for the past 30 days revealed no evidence of fluid intake provided or amount recorded.<br><br>Observation on 11/12/24 from 2:48 P.M. to 2:56 P.M. of the south and skilled halls revealed hydration cups were not consistently observed in resident rooms.<br><br>Interview on 11/13/24 at 1:11 P.M. with Resident #121 revealed water is not provided between meals unless asked for and not always brought back quickly.<br><br>Observation on Interview on 11/20/24 at 7:25 A.M. while walking in the resident hallway with the Assistant Director of Nursing (ADON) confirmed hydration cups were not visible for all appropriate resident rooms and confirmed water is to be passed to appropriate residents each shift.<br><br>Review of the 11/2018 revised facility policy called; Hydration/Fresh Water and Fluids revealed State tested Nurse Aids (STNAs) will provide fresh ice water to residents each shift. Repeat fresh water delivery as needed throughout the shift and upon request for fresh water.<br><br>2. Review of the medical record for Resident #122 revealed an admitted [DATE]. Diagnoses included but were not limited to acute postprocedural respiratory failure, hemiplegia, dependence on respirator, type II diabetes mellitus, moderate protein calorie malnutrition.<br><br>(continued on next page) |

| 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 12/02/2024 |
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| NAME OF PROVIDER OR SUPPLIER Grande Oaks | | STREET ADDRESS, CITY, STATE, ZIP CODE 24579 Broadway Ave Oakwood Village, OH 44146 | |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of 10/02/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #122 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) revealed resident required set up for meals.<br><br>Review of Resident #122's care plan which was last reviewed on 10/19/24 revealed she was at risk for alteration in hydration related to chronically elevated blood urea nitrogen (BUN)/creatinine which was likely a reflection of congestive heart failure. Interventions were to record meal intake including fluids.<br><br>Review of the electronic medical record under the hydration task for the past 30 days for Resident #122 for the past 30 days revealed no evidence of fluid intake provided or amount recorded.<br><br>Observation on 11/12/24 from 2:48 P.M. to 2:56 P.M. of the south and skilled halls revealed hydration cups were not consistently observed in resident rooms.<br><br>Observation on Interview on 11/20/24 at 7:25 A.M. while walking in the resident hallway with the ADON confirmed hydration cups were not visible for all appropriate resident rooms and confirmed water is to be passed to appropriate residents each shift.<br><br>Interview on 11/21/24 at 1:12 P.M. with Resident #122 revealed water is not consistently offered between meals and she will ask for it.<br><br>Review of the 11/2018 revised facility policy called; Hydration/Fresh Water and Fluids revealed State tested Nurse Aids (STNAs) will provide fresh ice water to residents each shift. Repeat fresh water delivery as needed throughout the shift and upon request for fresh water.<br><br>3. Observation on 11/12/24 from 2:48 P.M. to 2:56 P.M. of the south and skilled halls revealed hydration cups were not consistently observed in resident rooms.<br><br>Observation on Interview on 11/20/24 at 7:25 A.M. while walking in the resident hallway with the ADON confirmed hydration cups were not visible for all appropriate resident rooms and confirmed water is to be passed to appropriate residents each shift.<br><br>Interview on 11/20/24 at 2:49 P.M. with Resident #137 revealed water is not always passed between meals and she has to ask for it.<br><br>Interview on 11/20/24 at 2:55 P.M. with Licensed Practical Nurse (LPN) #302 revealed she was unsure how often water was passed to the residents since nursing assistants pass water.<br><br>Interview on 11/20/24 at 3:02 P.M. with Certified Nurse Aide (CNA) #233 revealed water is supposed to be pass every shift and at meals but is not consistently passed between meals.<br><br>Interview on 11/20/24 at 3:10 P.M. with Resident #125 revealed water is not consistently passed and she has to asks for it.<br><br>Interview on 11/20/24 at 3:20 P.M. with LPN #301 revealed water is passed during meals and when a resident asks for a drink.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365825 | A. Building<br>B. Wing | 12/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grande Oaks | 24579 Broadway Ave<br>Oakwood Village, OH 44146 |

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|---|---|
| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 11/20/24 at 3:24 P.M. with LPN #304 revealed water is supposed to be passed each shift to residents by the CNAs. LPN #304 stated she will give residents when they ask for it but does not always have time to check each room to ensure water was passed to all residents.<br><br>Interview on 11/21/24 at 3:02 P.M. with CNA #224 revealed she passed water to residents whenever they ask for it.<br><br>Review of the 11/2018 revised facility policy called; Hydration/Fresh Water and Fluids revealed State tested Nurse Aids (STNAs) will provide fresh ice water to residents each shift. Repeat fresh water delivery as needed throughout the shift and upon request for fresh water.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159004. |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on observation, staff and resident interviews, and review of facility mealtimes and policy, the facility failed to ensure meals were provided at posted time and residents were offered a snack as required when there was greater than 14 hours between dinner and breakfast. This had the potential to affect all 41 residents receiving meals from the kitchen. The facility identified eight residents (Residents #107, #110, #113, #115, #116, #117, #119, and #152) who received nothing by mouth. The facility census was 49.<br><br>Findings include:<br><br>1. Observation of lunch tray line temperatures on 11/12/24 at 12:18 P.M. with [NAME] #253 revealed tray line started at 12:20 P.M. which ran until 12:40 P.M. for the adjacent facility which had a separate license. Tray line for Grande Oaks started at 12:40 P.M. Tray line stopped at 1:14 P.M due to running out of the white and wild rice. Five trays (Resident #147, #148, #149, #150 and #151) were left to finish. [NAME] # 253 confirmed due to running out of rice, the last five trays were delayed while more rice was made.<br><br>Observation on 11/12/24 at 1:23 P.M. tray line resumed and finished at 1:25 P.M. Last food service cart arrived to the south hall at 1:28 P.M. Tray pass was initiated and finished at 1:40 P.M. DM #266 confirmed the tray was later than 45 minutes past the posted delivery time.<br><br>Review of the undated posting called Grande Oaks and Grande Pavillion Snack Times hanging on the wall by the nurse's station stated Snacks are brought to each unit form the dietary department daily at the following times: 10 am, 2pm, and HS (between 7 and 7:30 pm).<br><br>Review of the October 2017 revised facility policy called; Food and Nutrition Services revealed meals will be provided within 45 minutes of either resident request or scheduled mealtime and in accordance with the resident's medical requirements. Nourishing snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snack may be scheduled between meals to accommodate the resident's typical eating patterns.<br><br>2. Review of the medical record for Resident #121 revealed an admitted [DATE]. Diagnoses included but were not limited to chronic respiratory failure, dependence upon a respirator, vascular dementia, and obesity.<br><br>Review of 09/14/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #121 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated resident was cognitively intact. Review of activities of daily living (ADLs) revealed resident requires supervision for meals.<br><br>Review of the snack task for Resident #121 for the past 30 days revealed six entries all of which indicated not applicable.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Grande Oaks | | STREET ADDRESS, CITY, STATE, ZIP CODE: 24579 Broadway Ave Oakwood Village, OH 44146 | |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 11/20/24 at 7:36 A.M. with Resident #121 revealed she did not receive her dinner tray on 11/18/24 till after 6:00 P.M. when she used her call light to ask about her dinner tray.<br><br>Review of the undated posting called Grande Oaks and Grande Pavillion Snack Times hanging on the wall by the nurse's station stated Snacks are brought to each unit form the dietary department daily at the following times: 10 A.M., 2 P.M., and HS (between 7 and 7:30 P.M.).<br><br>Review of the October 2017 revised facility policy called; Food and Nutrition Services revealed meals will be provided within 45 minutes of either resident request or scheduled mealtime and in accordance with the resident's medical requirements. Nourishing snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snack may be scheduled between meals to accommodate the resident's typical eating patterns.<br><br>Review of the 01/01/24 revised facility policy called; Frequency of Meals revealed there will no more than 14 hours between an evening meal and breakfast the following day unless a nourishing snack is served at bedtime; then up to 16 hours may elapse between an evening meal and breakfast the following day if the resident council agrees to this mealtime span. Nutritious snacks and convenience foods (i.e. Canned soups, peanut butter, crackers, cereal and fruit) shall be available on the nursing units for those residents who request food outside scheduled meal and snack times.<br><br>Review of the undated facility policy called; Snack and Nourishment Policy revealed snacks and nourishments will be available to all resident upon request throughout the day and evening. All residents should be offered a snack at bedtime. Dietary department is to prepare nightly snack and nourishment trays to distribute to each resident unit daily.<br><br>3. Review of the medical record for Resident #122 revealed an admitted [DATE]. Diagnoses included but are not limited to acute postprocedural respiratory failure, hemiplegia, dependence on respirator, type II diabetes mellitus, moderate protein calorie malnutrition.<br><br>Review of 10/02/24 quarterly Minimum Data Set (MDS) 3.0 for Resident #122 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) revealed resident required set up for eating.<br><br>Review of the medical record under snack task for Resident #122 revealed three entries recorded over the past 30 days.<br><br>Interview on 11/12/24 at 12:03 P.M. with Resident #122 revealed she does not get offered snacks at night unless she asks, and they are not always available.<br><br>Review of the undated posting called Grande Oaks and Grande Pavillion Snack Times hanging on the wall by the nurse's station stated Snacks are brought to each unit form the dietary department daily at the following times: 10 A.M., 2 P.M., and HS (between 7 and 7:30 P.M.).<br><br>Review of the October 2017 revised facility policy called; Food and Nutrition Services revealed meals will be provided within 45 minutes of either resident request or scheduled mealtime and in accordance with the resident's medical requirements. Nourishing snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snack may be scheduled between meals to accommodate the resident's typical eating patterns.<br><br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the 01/01/24 revised facility policy called; Frequency of Meals revealed there will no more than 14 hours between an evening meal and breakfast the following day unless a nourishing snack is served at bedtime; then up to 16 hours may elapse between an evening meal and breakfast the following day if the resident council agrees to this mealtime span. Nutritious snacks and convenience foods (i.e. Canned soups, peanut butter, crackers, cereal and fruit) shall be available on the nursing units for those residents who request food outside scheduled meal and snack times.<br><br>Review of the undated facility policy called; Snack and Nourishment Policy revealed snacks and nourishments will be available to all resident upon request throughout the day and evening. All residents should be offered a snack at bedtime. Dietary department is to prepare nightly snack and nourishment trays to distribute to each resident unit daily.<br><br>4. Interview on 11/13/24 at 5:05 A.M. with Licensed Practical Nurse (LPN) #293 revealed snacks are not consistently sent and has brought in snacks from home for residents who ask for a snack.<br><br>Interview on 11/13/24 at 5:36 A.M. with Certified Nurse Aide (CNA) #232 revealed sometimes not enough snacks sent and sometimes no snacks are delivered and stated no snacks were sent at night last Saturday or Sunday night.<br><br>Interview on 11/13/24 at 5:47 A.M. with CNA #224 revealed snacks are not available most nights and staff bring in snacks to give to residents.<br><br>Interview on 11/13/24 at 1:11 P.M. with Resident #121 revealed no snacks are provided between meals unless she asks and are not always available.<br><br>Additional interview on 11/14/24 at 7:01 A.M. with CNA #232 revealed there are no snacks to pass or only three to four provided to pass for the whole unit. After dinner the kitchen is closed so there is no one to contact and a lot of residents will ask but staff do not have snacks to give and stated it has previously been reported to the nurse and Assistant Director of Nursing (ADON).<br><br>Interview on 11/18/24 at 7:00 A.M. with CNA #234 confirmed there were no snacks provided to pass for the evening snack when she arrived at 7:00 P.M. on 11/17/24.<br><br>Interview on 11/18/24 at 12:05 P.M. with LPN #290 confirmed there was no 10:00 A.M. snacks provided today.<br><br>Interview on 11/18/24 at 12:24 P.M. with LPN #299 confirmed there were no snacks provided between breakfast and lunch.<br><br>Interview on 11/19/24 at 1:03 P.M. with Dietary Manager #266 confirmed snacks are sent daily at 10:00 A.M. , 2:00 P.M. and between 7:00-7:30 P.M. Dietary Manager #266 was unable to provide evidence of snack lists provided for the past 30 days.<br><br>Interview on 11/20/24 at 7:03 A.M. with LPN #300 confirmed frequently there are no snacks sent for the evening snack after dinner and stated sometimes staff will bring in snacks from home to give the residents.<br><br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 11/20/24 at 2:49 P.M. with Resident #137 revealed snacks are not always available at night unless you ask for them.<br><br>Interview on 11/20/24 at 2:55 P.M. with LPN #302 revealed snacks are not consistently given.<br><br>Interview on 11/20/24 at 3:10 P.M. with Resident #125 revealed she never gets offered snacks unless she asks.<br><br>Interview on 11/20/24 at 3:16 P.M. with Resident #101 revealed is told they do not have snacks available to pass.<br><br>Review of the undated facility document titled Grande Oak Meal Times revealed there were over 15 hours between dinner and breakfast as evidenced by:<br><br>Breakfast 8:30 A.M.<br><br>Lunch 12:30 P.M.<br><br>Dinner 5:00 P.M.<br><br>Interview on 11/19/24 at 1:03 P.M. with Dietitian #267 confirmed the posted mealtime schedule is outside of the 14-hour requirement and also confirmed snacks were not being consistently recorded.<br><br>Review of the undated posting called Grande Oaks and Grande Pavillion Snack Times hanging on the wall by the nurse's station stated Snacks are brought to each unit form the dietary department daily at the following times: 10 am, 2pm, and HS (between 7 and 7:30 pm).<br><br>Review of the October 2017 revised facility policy called; Food and Nutrition Services revealed meals will be provided within 45 minutes of either resident request or scheduled mealtime and in accordance with the resident's medical requirements. Nourishing snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snack may be scheduled between meals to accommodate the resident's typical eating patterns.<br><br>Review of the 01/01/24 revised facility policy called; Frequency of Meals revealed there will no more than 14 hours between an evening meal and breakfast the following day unless a nourishing snack is served at bedtime; then up to 16 hours may elapse between an evening meal and breakfast the following day if the resident council agrees to this mealtime span. Nutritious snacks and convenience foods (i.e. Canned soups, peanut butter, crackers, cereal and fruit) shall be available on the nursing units for those residents who request food outside scheduled meal and snack times.<br><br>Review of the undated facility policy called; Snack and Nourishment Policy revealed snacks and nourishments will be available to all resident upon request throughout the day and evening. All residents should be offered a snack at bedtime. Dietary department is to prepare nightly snack and nourishment trays to distribute to each resident unit daily.<br><br>5. Phone interview from an anonymous family member on 11/21/24 at 10:59 A.M. stated dinner on 11/20/24 which was supposed to arrive at 5:00 P.M. did not arrive until 6:48 P.M.<br><br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Phone interview from an anonymous family member on 11/21/24 at 11:25 A.M. stated dinner has not been arriving till after 6:00 P.M. for several months.<br><br>Interview on 11/21/24 at 3:24 P.M. with the Administrator confirmed she was aware of the reported concern of dinner trays being late on 11/20/24. The Administrator stated the dish machine was not working properly and Dietary Manager #266 left to get more disposable supplies for the dinner tray line which caused the delay in meal service.<br><br>Review of the October 2017 revised facility policy called; Food and Nutrition Services revealed meals will be provided within 45 minutes of either resident request or scheduled mealtime and in accordance with the resident's medical requirements. Nourishing snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snack may be scheduled between meals to accommodate the resident's typical eating patterns.<br><br>Review of the 01/01/24 revised facility policy called; Frequency of Meals revealed there will no more than 14 hours between an evening meal and breakfast the following day unless a nourishing snack is served at bedtime; then up to 16 hours may elapse between an evening meal and breakfast the following day if the resident council agrees to this mealtime span. Nutritious snacks and convenience foods (i.e. Canned soups, peanut butter, crackers, cereal and fruit) shall be available on the nursing units for those residents who request food outside scheduled meal and snack times.<br><br>6. Observation on 11/25/24 at 5:42 P.M. revealed Maintenance Director delivered the first dining cart to the south unit.<br><br>Observation on 11/25/24 at 5:47 P.M. revealed the Administrator delivered the second dining cart to the south unit.<br><br>Observation on 11/25/24 at 5:52 P.M. revealed the Administrator delivered the third dining cart to the skilled unit.<br><br>Interview on 11/25/24 at 5:58 P.M. with the Administrator confirmed the dining carts were more than 45 minutes past the posted dinner time and was unsure what had caused the dining carts to be late.<br><br>Review of the undated posting called Grande Oaks and Grande Pavillion Snack Times hanging on the wall by the nurse's station stated Snacks are brought to each unit form the dietary department daily at the following times: 10 A.M., 2 P.M., and HS (between 7 and 7:30 P.M.).<br><br>Review of the October 2017 revised facility policy called; Food and Nutrition Services revealed meals will be provided within 45 minutes of either resident request or scheduled mealtime and in accordance with the resident's medical requirements. Nourishing snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snack may be scheduled between meals to accommodate the resident's typical eating patterns.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Grande Oaks | | STREET ADDRESS, CITY, STATE, ZIP CODE 24579 Broadway Ave Oakwood Village, OH 44146 | |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the 01/01/24 revised facility policy called; Frequency of Meals revealed there will no more than 14 hours between an evening meal and breakfast the following day unless a nourishing snack is served at bedtime; then up to 16 hours may elapse between an evening meal and breakfast the following day if the resident council agrees to this mealtime span. Nutritious snacks and convenience foods (i.e. Canned soups, peanut butter, crackers, cereal and fruit) shall be available on the nursing units for those residents who request food outside scheduled meal and snack times.<br><br>Review of the undated facility policy called; Snack and Nourishment Policy revealed snacks and nourishments will be available to all resident upon request throughout the day and evening. All residents should be offered a snack at bedtime. Dietary department is to prepare nightly snack and nourishment trays to distribute to each resident unit daily.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00160067 and OH00160072, and OH00159004. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>45442<br><br>Based on observation, interview and facility policy review, the facility failed to consistently ensure food was stored and served under sanitary conditions. This had the potential to affect 41 residents who received food from the kitchen. The facility identified eight residents (Residents #107, #110, #113, #115, #116, #117, #119, and #152) who received nothing by mouth. The facility census was 49.<br><br>Findings include:<br><br>Observation during the initial kitchen tour conducted on 11/12/24 at 9:27 A.M. with [NAME] #253 revealed the low temperature dish machine reached the appropriate temperature of 125.6 Fahrenheit (F), but the chlorine chemical test strip did not change color and remained white and unchanged from when put in the dish machine prior to start of the cycle. [NAME] #253 confirmed and stated disposable dishes would be used until the dish machine was fixed.<br><br>Observation on 11/12/24 at 10:00 A.M. with Dietary Manager (DM) #266 confirmed the temperature logs for the dish machine were not completed since 11/06/24, confirmed there were no cleaning logs for September, October or for November to date. DM #266 also confirmed the sanitizer bucket test log was not completed and only had through 11/06/24, the three compartment sink log was also not completed past 11/06/24.<br><br>Observation on 11/12/24 at 1:20 P.M. with DM #266 confirmed the exhaust fan near the ceiling on the back wall across from the serving line was heavily soiled with dark brown dust on the grates which blew out towards the serving line.<br><br>Review of the undated facility policy called; Sanitary Conditions revealed all equipment will be maintained in a clean and sanitary fashion. The Food Service Director will establish a schedule for cleaning and sanitizing of all equipment. Dish machine temperatures will be maintained as follows 120 degrees Fahrenheit for wash with 50 parts per million Hypochlorite. A temperature log will be maintained.<br><br>Review of the undated facility policy called; Dishwashing Procedure revealed dish machine temperature log will be completed for every meal.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159004. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on observation, interviews and facility policy review, the facility failed to ensure safe handling of resident food brought in from outside the facility. This has the potential to affect 41 residents who received food from the kitchen. The facility identified eight residents (Residents #107, #110, #113, #115, #116, #117, #119, and #152) who received nothing by mouth. The facility census was 49.<br><br>Findings include:<br><br>Observation on 11/12/24 at 10:20 A.M. with Dietary Manager (DM) #266 revealed on the south resident hall the resident refrigerator at the nurse's station revealed three unlabeled, undated meat sandwiches, no evidence of temperature monitoring logs for the refrigerator and the unit microwave had dried food particles stuck to the ceiling and the sides of the microwave. No temperature logs were located on or near the refrigerator. DM #266 confirmed the above findings at the time of the observation.<br><br>Observation on 11/12/24 at 10:25 A.M. with DM #266 revealed the resident refrigerator on the skilled hallway by the nurse's station revealed the following concerns: an unlabeled, undated plastic container of ice cream from a fast food restaurant open to air, a 20 ounce open, undated bottle of ketchup with no resident name listed, an open, undated 16 ounce bottle of spicy ranch dressing that had an expiration date of 06/13/24, a 16 ounce bottle of open, undated bottle of [NAME] sauce with an expiration date of 08/12/24, an open undated bottle of boost nutritional supplement with an expiration date of 01/26/25 that was undated and was not labeled with a resident name, an 11.6 ounce package of undated Black Pepper and Sage Pork Chop with an expiration date of 10/02/24, an undated, unlabeled bag of employee pumped breast milk, a Ziploc sandwich bag which was not labeled with a name or date and appeared to be discolored and was unable to identify what the contents were. No temperature monitoring logs were found on or near the refrigerator. The above findings were confirmed by DM #266 and the Assistant Director of Nursing (ADON). The ADON confirmed employee foods and breast milk were not to be stored in the resident refrigerator.<br><br>Review of the undated facility policy with no title revealed to ensure safe and sanitary storage, handling and consumption of food brought in for resident consumption from home, restaurant, or carryout, residents, family and staff will be education on standard food safety procedures. Staff will follow the safe food handling protocol when handling resident food. No staff food may be stored in unit refrigerators. All prepared/perishable food or beverages brought in by resident, family or visitors for resident's use will be labeled with the resident's name and the date the item was stored. Food will be kept for five days from labeled date and then discarded unless it is a condiment which will be kept for two months/60 days. Any food or beverage that is not labeled with resident name and dated will be discarded immediately.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159004. |

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| F 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>43063<br><br>Based on record review and interviews, the facility failed to ensure accurate direct care staffing information was submitted to the Centers for Medicare and Medicaid Services (CMS). This had the potential to affect all 49 residents residing in the facility.<br><br>Findings include:<br><br>Review of the punch details dated from 10/14/24 through 10/18/24 revealed Nurse Practitioner #330 was listed at eight hours each day under nursing, Registered Nurse (RN) and RN wages.<br><br>Interview on 11/21/24 at 11:58 A.M. with Human Resources Director #287 revealed Nurse Practitioner #330 was not on the staffing schedule, however, she had listed her on the punch details as an RN. She was not aware what her actual role at the facility was but knew that she did come in and work at the facility. After obtaining the answer of where Nurse Practitioner #330 worked in the building, she returned and stated she was actually working as the nurse practitioner at the facility. She stated she had been entering Nurse Practitioner #330's hours in the payroll-based journal (PBJ) as she believed she could still utilize her hours as an RN.<br><br>Interview on 11/21/24 at 12:15 P.M. with the Administrator verified the Human Resources Director #287 should not have been entering Nurse Practitioner #330's hours in the PBJ as an RN as she was working as a nurse practitioner during the time frames listed above. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442<br><br>Based on observation, staff interview, repair invoice, and cleaning checklists, the facility failed ensure wheelchairs were being cleaned as required, failed to ensure shower rooms and equipment was maintained in a sanitary manner, and failed to ensure facility phones were in working order. This had the potential to affect all 49 residents residing at the facility.<br><br>Findings include:<br><br>1. Observation on 11/12/24 at 3:38 P.M. with the Administrator revealed the following concerns:<br><br>- The power wheelchair for Resident #137 was heavily soiled and a used disposable glove was found behind the seat.<br><br>-The power wheelchair for Resident #135 had a visible dried spill on the seat, food crumbs on the seat and a dried spill that was on the seat which ran over the back and down the seat cushion<br><br>-The power wheelchair for Resident #101 had dried soil on the front side of the upper back cushion and footrest had multiple visible dried spills.<br><br>Following the above observations, the Administrator confirmed the above findings and stated the wheelchairs are to be cleaned on resident shower days and as needed.<br><br>Review of the undated facility skilled shower schedule and wheelchair cleaning schedule revealed each resident is showered at least two times a week and on their shower day wheelchairs are to be cleaned.<br><br>2. Observation on 11/13/24 at 4:48 A.M. revealed a two separate doorbells inside the entrance of the facility by the locked entrance door. A sign was located on the wall between the first and second entrance door that stated, For the safety of our residents and staff, this door will be locked after hours. If you are an authorized visitor and wish to gain entry into the facility after hours, please call one of the numbers below. A staff member will come verify your authorization and assist you with your entrance into the facility. Grande Oaks Skilled Nursing Station (440)658-1476, Grande Oaks South Nursing Station TBD (for the time being call Grand Oaks Skilled Station), Grande Pavilion Nurses Station #1 (440)658-1420, and Grande Pavilion Nurses Station #2 (440) [PHONE NUMBER].<br><br>Surveyor rang both doorbells on 11/13/24 at 4:50 A.M. with no audible sound when pushed.<br><br>Surveyor called the following phone numbers in attempt to enter the facility:<br><br>-phone number (440) [PHONE NUMBER] was called at 4:56 A.M. which rang multiple times and then disconnected.<br><br>-phone number (440) [PHONE NUMBER] was called at 4:56 A.M. which rang multiple times and disconnected.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -phone number (440) [PHONE NUMBER] was called at 4:57 A.M. which rang multiple times and disconnected<br><br>-phone number (440) [PHONE NUMBER] was called at 5:00 A.M. which rang multiple times and disconnected<br><br>-phone number (440) [PHONE NUMBER] was called at 5:00 A.M. which rang multiple times and disconnected<br><br>-phone number (440) [PHONE NUMBER] was called at 5:01 A.M. rang and was answered by Licensed Practical Nurse (LPN) #293 who stated she would come to the entrance to open the door.<br><br>Entrance was obtained to the facility on [DATE] at 5:05 A.M.<br><br>Observation on 11/13/24 at 5:22 A.M. with LPN #293 at the skilled unit phone (440 )658-1476 revealed when the nursing station phone was called, the phone lit up but did not audibly ring. LPN #293 confirmed the phone did not audibly ring at the time of the observation and stated if no one was at the nurse's station, staff would not know someone was trying to call the facility.<br><br>Observation on 11/13/24 at 5:25 A.M. and 5:27 A.M. on the south unit, revealed the south unit phone did not ring or light up when (440) [PHONE NUMBER] or (440) [PHONE NUMBER] was called. LPN #306 confirmed the phone did not ring when either number was called at the time of the observation.<br><br>Interview on 11/13/24 at 6:45 A.M. with the Administrator stated the facility is in process of getting a new phone system. Stated a weekend or two ago they had a phone issue, but maintenance came in and reset the phones. Administrator stated she was not aware of further phone issues since then.<br><br>Interview on 11/13/24 at 8:47 A.M. with Regional Director of Operations (RDO) #355 stated the facility was getting a new phone system and confirmed the current system was not fully functioning currently.<br><br>Phone interview on 11/18/24 at 3:04 P.M. with [NAME] President (VP) of Operations #357 stated the facility had issues with the phones back in the middle of June 2024 which included phone calls being dropped and transferred calls being dropped and they worked with the contracted phone company for the repairs and left the help ticket upon till beginning of July to ensure there were no further issues. The ticket was re-opened in October and following diagnosis the facility determined the phone system needed to be replaced. VP of Operations #357 stated he was aware of call being dropped during transfers and stated it takes about 30-45 days for the changeover of phones.<br><br>Review of the facility quote dated 10/22/24 for a new phone system revealed it was signed to get the new phone system in progress on 10/23/24.<br><br>Review of the email correspondence dated 11/22/24 timed at 4:48 P.M. from VP of Operations #357 revealed the initial ticket for phone issues was reported on 06/25/24 and was fixed on the same day. A new concern was reported on 10/08/24. It was identified that the system was not fixable and required a new system to be installed. The system was still in operation but were still having issues trying to transfer calls and some calls were dropped. The facility was directing families to call staff member personal phones directly with concerns.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 11/25/24 at 10:13 A.M. with the Director of Nursing (DON) confirmed not all resident families were made aware of the facility phone issues related to incoming calls.<br><br>Interview on 11/25/24 at 4:06 P.M. with the Administrator confirmed the facility did not send out a letter of communication to residents, resident families or outside providers to alert them of the facility phone issues or how to alternatively contact the facility.<br><br>3. Observation on 11/18/24 at 3:40 P.M. with the DON revealed the following concerns:<br><br>-south hall shower room had black mold-like stains on the white wall tiles that wiped off with a paper towel in the shower area on three sides that went up about 12 inches as well as the eight of the adjoining floor tiles.<br><br>Observation on 11/18/24 at 3:46 P.M. with DON revealed the following concerns:<br><br>-skilled hall shower room had black mold-like discoloration that wiped off with a paper towel on the white tiles on three sides of the shower walls going up from the floor between six to nine inches.<br><br>-One large white wall tile was missing near the floor and was exposed to the wood stud.<br><br>-The adjacent shower area near the shower bed revealed black colored stains on the wall that appeared to be mold-like and wiped off with a paper towel.<br><br>-The flat shower bed revealed dried feces on the side of the bed and dried feces on the shower floor underneath the shower bed.<br><br>The DON confirmed the above findings at the time of the observations and confirmed the aides are to be cleaning the showers and shower chair/bed after each shower.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159247, Complaint Number OH00159004, and Complaint Number OH00158878. |