STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365825	A. Building B. Wing	10/28/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interviews and review of facility policy, the facility failed to ensure resident preferences were honored as requested. This affected one (Resident #19) of three reviewed for resident preferences. The facility census was 48. Findings include:1. Review of the medical record for Resident #19 revealed an admission date of 06/07/24. Diagnoses included but were not limited to interstitial pulmonary disease, dependence on respirator, chronic respiratory failure, supraventricular tachycardia, neuropathy, chronic obstructive pulmonary disease, disorders of diaphragm, obstructive sleep apnea, and chronic respiratory failure with hypoxia, obesity and anxiety disorder. Review of Resident #19's care plan revealed the resident required assistance with activities of daily living (ADL) related to spinal stenosis, peripheral neuropathy, and chronic obstructive pulmonary disease (COPD). An intervention dated 07/09/25 was listed as a soft touch pad call light is to be clipped to resident's gown at all times. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #19 revealed a Brief Interview of Mental Status (BIMS) score of 15 of 15, which indicated intact cognition. Review of the ADL revealed Resident #19 required set up for eating, and was dependent on staff for toileting, bathing, dressing and transfers. Interview on 10/16/25 at 6:55 A.M. with Certified Nursing Assistant (CNA) #203 stated Resident #19's call light does not light up on the call system at the nurse's station, but it does light up in the hall and alarm when it is pushed. CNA #203 stated when they identify an issue they report it to the nurse. Interview on 10/16/25 at 9:40 A.M. with Maintenance Director #300 revealed he was unaware of any concerns related to Resident #19's call system and was unaware she needed one. Observation on 10/16/25 at 10:12 A.M. with Resident #19 revealed a push button call light at the right side of the bed and was tied in a knot to the bed frame. Interview at the time of the observation with Resident #19 revealed it was hard to push due to dexterity problems. Interview and observation on 10/16/25 at 10:15 A.M. with the Director of Nursing (DON) confirmed Resident #19 had a push button call light and did not have a call pad as requested. Interview on 10/16/25 at 11:04 A.M. with the DON confirmed the facility had a meeting with Resident #19 and her daughter with the Ombudsmen and a call pad was a preference requested. The DON confirmed Resident #19 did not have the call pad as agreed upon. Review of the 04/01/22 revised facility policy called; Call Lights: Accessibility and Timely Response revealed each resident will be evaluated for unique needs and preferences to determine any special accommodation that may be needed for the resident to utilize the call system. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide alternative solutions until the problem can be remedied. 2. Review of the medical record for Resident #19 revealed an admission date of 06/07/24. Diagnoses included but were not limited to interstitial pulmonary disease, dependence on respirator, chronic respiratory failure, supraventricular tachycardia, neuropathy, COPD, disorders of diaphragm, obstructive sleep apnea, and chronic respiratory failure with hypoxia, obesity and anxiety disorder. Resident #19 was noted to receive a minced and moist diet with thin liquids. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #19 revealed a BIMS score of 15 of 15, which indicated intact cognition. Review of the ADL revealed Resident #19 required staff to set up meals. Resident #19 was noted to receive a mechanically altered diet. Review of the photo submitted by Resident #19's daughter on 10/21/25 of the lunch for 10/20/25 revealed a divided plate with penne pasta with meat sauce, cooked broccoli and carrots and a dinner roll. Review of the meal ticket dated 10/21/25 for Resident #19 revealed a diet order of regular minced and moist with thin liquids. Applesauce with meals, no bread, give biscuit mashed up with gravy. Interview on 10/22/25 at 8:37 A.M. with Food Service Director (FSD) #297 confirmed the photo submitted by Resident #19's daughter from 10/20/25 had a roll on the plate and per her request should not have had bread on it. FSD #297 confirmed broccoli, and carrots were substituted for tossed salad per her diet order. Review of the undated facility policy called; Resident Rights revealed the resident has the right to be informed of, and participate in his or her treatment including; the right to participate in establishing the expected goals and outcomes of care, the type, amount frequently and duration of care and any other factored s related to the effectiveness of the plan of care. This deficiency represents non-compliance investigated under Complaint Number 2643354.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interviews and facility policy review, the facility failed to ensure documentation of ongoing monitoring and evaluations for the continued use of a restraint and the usage of other interventions for reducing or discontinuing the use of the restraint. This affected one (Resident #50) out of six medical records which were reviewed. The facility census was 48. Findings include:Closed record review for Resident #50 revealed the resident was admitted to the facility on [DATE] and expired on [DATE] with the following diagnoses: acute respiratory failure, chronic obstructive pulmonary disease (COPD), encephalopathy, dependence on ventilator, gastrostomy, cerebral infarction, tracheostomy, mood disorders, atrial fibrillation, anxiety, hypertension, diabetes. This resident had no known allergies and was a full code. Review of the provider orders for Resident #50 dated [DATE] revealed an order for mitt restraints to assist with safety, check skin with donning and doffing every shift. The order did not include the diagnosis, any breaks in restraint usage, or any monitoring for effectiveness with use of less restrictive interventions. Review of the nursing progress notes on [DATE] at 5:09 P.M. revealed a new order for hand mitts, and hand mitts were applied to right and left hands of Resident #50. Review of the nursing progress notes revealed mitt restraint with skin assessments were completed on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. No other days had documentation of ongoing need, usage, or evaluation of continued restraints as required. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #50 had significant impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of zero of 15. Resident #50 was assessed to require maximum assistant and dependence on staff for activities of daily living (ADL), hygiene, grooming, turning and repositioning, and transfers with Hoyer (mechanical) lift to the wheelchair. Resident #50 had an indwelling catheter and was always incontinent of bowel. Resident #50 was to receive NPO (nothing by mouth) and required enteral feeding for nutrition and hydration and was ventilator dependent per tracheostomy. Resident #50 had marked confusion and encephalopathy and would attempt to pull and disconnect ventilator circuit from self. Review of Medication Administration Record (MAR) for July and [DATE] revealed mitt restraints were signed off for each shift starting [DATE] through [DATE]. Review of the care plan revised on [DATE] revealed no specific goals and interventions regarding Resident #50's mitt restraints. The care plan did include the potential risk for falls/injury which did include inventions of: inspection of resident's skin around and under hand mitts, proper positioning with hand mitts and physician order for the device. It did not include any interventions or continued monitoring/assessments specific to usage of restraints or plans for removal. Interview with Director of Nursing (DON) on [DATE] at 2:00 P.M. revealed facility does have a policy on restraint usage and to use the least restrictive appliance for the shortest amount of time. She stated staff should be documenting restraint usage as well as alternatives that were attempted and the ongoing re-evaluation of the need for the restraint. DON also stated the restraints should be included in the resident's care plan. DON verified there was no documentation of effectiveness or the re-evaluation of mitt restraint usage for Resident #50. Interview with Respiratory Therapist (RT) #268 on [DATE] at 9:30 A.M. revealed Resident #50 was disoriented and would frequently try to decannulate her tracheostomy or remove the circuit from the ventilator. She was often disruptive and would not follow commands. RT #268 stated Resident #50 did require mitt restraints for resident safety but stated they were on all the time. He did not observe any time when they were off because she would be calm one moment then start pulling on the equipment a minute later. Interview with Nurse Practitioner (NP) #303 on [DATE] at 8:19 A.M. revealed that Resident #50 did require the mitt restraints to maintain patient safety and continued treatment plan. She was unsure of requirements at the facility for the care and management of restraints and thought the order needed to be renewed daily; however, this was not included in the facility policy. NP #303 also revealed whenever she was visiting Resident #50, the restraints were always on the resident, and she was still able to try to remove the equipment from her. NP #303 consulted with the resident's psych team regarding psychotropic medications to assist resident with anxiety needs and harmful behaviors. Interview with Licensed Practical Nurse (LPN) #248 on [DATE] at 2:03 P.M. revealed she routinely cared for Resident #50 and stated she needed the mitt restraints because the resident would frequently exhibit behaviors of attempting to pull the ventilator circuit off, removing her tracheostomy, thrashing out at care providers, pulling on Foley (indwelling) catheter, and actively attempting to get out of bed. LPN #248 stated there was no specific daily checklist for restraint guidance and usage, but staff are

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure all ordered treatments/medications were provided to residents as ordered. This affected one (Resident #19) out of four residents who were interviewed for ordered treatments/medications. The facility census was 48. Findings include:Review of the medical record for Resident #19 revealed an admission date of 06/07/24. Diagnoses included but were not limited to interstitial pulmonary disease, dependence on respirator, chronic respiratory failure, supraventricular tachycardia, neuropathy, chronic obstructive pulmonary disease, disorders of diaphragm, obstructive sleep apnea, and chronic respiratory failure with hypoxia, obesity and anxiety disorder. Review of Resident #19's care plan revealed the resident required assistance with activities of daily living (ADL) related to spinal stenosis, peripheral neuropathy, and chronic obstructive pulmonary disease (COPD). An intervention dated 07/09/25 was listed as a soft touch pad call light is to be clipped to resident's gown at all times. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #19 revealed a Brief Interview of Mental Status (BIMS) score of 15 of 15, which indicated intact cognition. Review of the ADL revealed Resident #19 required set up for eating, and was dependent on staff for toileting, bathing, dressing and transfers. Review of the October 2025 physician's orders revealed an order for Biofreeze (pain relieving gel) topically to both knees dated 07/02/24. Interview with Resident #19 and daughter on 10/23/25 at 2:00 P.M. revealed concerns regarding the resident not receiving her ordered application of Biofreeze 4% gel (pain relieving gel) to her knees. Resident #19's daughter stated that on 10/25/25, Licensed Practical Nurse (LPN) #270 did not apply the Biofreeze as ordered after Resident #19 requested it. Interview with LPN #270 on 10/27/25 at 12:50 P.M. revealed that the Biofreeze was kept on Resident #19's bedside table and believed the resident was able to apply the gel herself when needed. LPN #270 did confirm that she did not actually apply the Biofreeze gel but did sign it off in the medication administration record (MAR) as being given. LPN #270 stated she would only sign off the medication if she thought the resident could apply it to herself. Interview with the Director of Nursing (DON) on 10/27/25 at 8:19 A.M. regarding signing off treatment in MAR revealed that LPN #270 should not have signed the medication as being administered if not performing the task herself or observing the resident performing the administration. The DON also stated that Resident #19 does not have the dexterity to self-apply the Biofreeze gel, and it should have been applied by LPN #270. The DON stated she will re-educate LPN #270 regarding documentation in MAR. Review of the facility policy titled, Medication Administration, revised on 08/22/22, revealed that staff is to review the MAR to identify medication which is to be administered and only sign the MAR after performing the administration. This deficiency represents non-compliance investigated under Complaint Number 2643354.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure physician orders were followed related to obtaining weights for two (Residents #11 and #19) of three residents reviewed for weight monitoring. The facility census was 48. Findings include:1. Review of the medical record for Resident #11 revealed an admission date of 04/14/22. Diagnoses included but were not limited to chronic respiratory failure, tracheostomy, dependence upon respirator, type II diabetes with hyperglycemia, and morbid obesity. The last weight recorded was on 07/02/25. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #11 revealed a Brief Interview of Mental Status (BIMS) score of 15 of 15, which indicated intact cognition. Review of activities of daily living (ADL) revealed Resident #11 was dependent upon staff for ADL. Review of Resident #11's care plan last reviewed on 09/04/25 revealed increased risk for malnutrition as evidenced by morbid obesity, diuretic use, and heart failure. Interventions listed were to monitor weight monthly and as needed. Review of nursing progress notes from 07/01/25 to 10/21/25 revealed a weight was obtained on 07/02/25, and no weight or refusal note was found for the month of August 2025, and refusal was noted for 09/12/25. Interview on 10/22/25 at 11:36 A.M. with the Director of Nursing (DON) confirmed she was unable to provide evidence of a monthly weight for Resident #11 for August 2025, or evidence of a noted refusal as required. 2. Review of the medical record for Resident #19 revealed an admission date of 06/07/24. Diagnoses included but were not limited to interstitial pulmonary disease, dependence on respirator, chronic respiratory failure, supraventricular tachycardia, neuropathy, chronic obstructive pulmonary disease (COPD), disorders of diaphragm, obstructive sleep apnea, and chronic respiratory failure with hypoxia, obesity and anxiety disorder. Review of Resident #19's nutrition care plan last reviewed on 04/14/25 revealed Resident #19 is at risk for alteration in nutrition and hydration related to obesity, tendency to become short of breath during meals. Interventions added on 06/12/24 included monitor weight monthly and as needed. Review of the 07/03/25 physician order for Resident #19 revealed an order to obtain weight daily at 5:00 A.M. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #19 revealed a BIMS score of 15 of 15, which indicated intact cognition. Review of ADL revealed Resident #19 was dependent upon staff for ADL. Review of the daily weights from 09/01/25 to 10/20/25 revealed no weights were recorded for 09/03/25, 09/06/25, 09/11/25, 09/13/25, 09/29/25, 10/02/25, 10/05/25, 10/12/25, 10/18/25 and 10/20/25. Interview on 10/22/25 at 9:32 A.M. with the DON confirmed the above daily weights were not obtained as ordered by the physician. Review of the 12/01/22 revised facility policy called; Weight Policy revealed weights should be recorded at the time obtained. Newly admitted residents- monitor weight weekly for four weeks. Residents with significant weight loss- monitor weight weekly. All others monitor weight monthly. Other conditions may require weights to be obtained and monitoring more frequently; physicians orders will determine the frequency. This deficiency represents non-compliance investigated under Complaint Number 2643354.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of videos provided by Resident #19's daughter and facility policy review, the facility failed to ensure external door ventilator alarms were monitoring and functioning appropriately for the safety for two (Residents #11 and #19). The facility also failed to ensure physician orders were followed related to nasal cannula being on for Resident #19 as ordered. This affected one (Resident #19) who used an Average Volume-Assured Pressure Support (AVAPS) and one resident (Resident #11) who used an Assist Control Volume Control (ACVC) ventilator of three residents reviewed for ventilator care and had the potential to affect eight additional (Residents #1, #5, #9, #10, #17, #18, and #49) identified by the facility as using AVAPS or ACVC ventilators. The facility census was 48. Findings include:1. Review of the medical record for Resident #19 revealed an admission date of 06/07/24. Diagnoses included but were not limited to interstitial pulmonary disease, dependence on respirator, chronic respiratory failure, supraventricular tachycardia, neuropathy, chronic obstructive pulmonary disease (COPD), disorders of diaphragm, obstructive sleep apnea, and chronic respiratory failure with hypoxia, obesity and anxiety disorder. Review of the physician order dated 02/03/25 for Resident #19 revealed an order to switch resident to bilevel positive airway pressure (BiPAP) 18/8 inspiration/expiration with respiratory rate of 18 with three-liter oxygen bleed-in during the day. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #19 revealed a Brief Interview of Mental Status (BIMS) score of 15 of 15, which indicated intact cognition. Review of the activities of daily living (ADL) revealed Resident #19 required set up for eating, and was dependent upon staff for toileting, bathing, dressing and required a Hoyer (mechanical) lift for transfers. Review of the physician order dated 09/23/25 for Resident #19 revealed an order for mechanical ventilation. Apply ventilation support vent settings continues AVAPs -AE VT (tidal volume) with a respiratory rate of eight. Expiratory Positive Airway Pressure (EPAP) 5-10 with a pressure support (PS) of 8-20 with three-liter oxygen bleed into the system for at least four hours and as needed. Review of the plan of care dated last reviewed on 10/06/25 revealed Resident #19 required assistance with ADL related to diagnoses of spinal stenosis, glaucoma, peripheral neuropathy, COPD and obesity. Interventions listed revealed Resident #19 required oxygen via the nasal cannula with all medication administration related to diminished lung capacity and aspiration risk. Review of the room video dated 10/14/25 timed at 7:34 A.M. provided by the daughter of Resident #19 revealed Resident #19 was yelling, Someone help me, please! multiple times. The internal AVAPS alarm was heard going off inside the room. The call light was noted to be tied to the side of the bed but not within the resident's reach. Certified Nursing Assistant (CNA) #218 is observed entering the room at 7:36 A.M. Resident #19 tells CNA #218 her oxygen hose is disconnected from her AVAPS and on the floor. CNA #218 is observed reattaching the oxygen hose and the AVAP alarm stops. CNA #218 assists her to reattach part of the mask strap and stated she would alert the nurse. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the video dated 10/14/25 timed at 7:41 A.M. provided by the daughter of Resident #19 revealed Resident #19 was observed with her AVAPS mask on, and the external door and internal alarm was not sounding. Respiratory Therapist (RT) #268 is noted to enter the room and is heard saying, and it didn't alarm? .outside? Resident #19 is heard saying.it did not alarm outside, she probably shut it off. RT #268 is seen leaving the room and then a beep occurs when the external alarm outside the room is turned back on. RT #268 immediately enters back into the room and states, Sorry about that [NAME], are you okay? Would you like breathing treatment? I will go and start you on a breathing treatment. Review of the video did not indicate the mask appeared to be broken, and Resident #19 was observed to be able to speak clearly and take sips of water with no issues. Review of the physician note dated 10/14/25 timed at 9:00 A.M. revealed Resident #19 has a history of hypertension, congestive heart failure, mild dementia, supraventricular tachycardia (heart rhythm disorder), bronchiectasis (chronic long condition characterized by permanent widening and thickening of the airways in the lungs), pulmonary embolism (blood clot that blocks and stops blood flow to an artery in the lung) and restrictive lung disease requiring a BiPAP almost around the clock upon admission. Resident #19 noted to be tolerating AVAPS well and intermittently on nasal canula (NC) during the day while eating. Resident #19 noted to have overall stable respiratory status. Phone interview on 10/16/25 at 10:30 A.M. with RT #268 revealed that the AVAPS non-invasive ventilator system has two types of alarms; an external alarm that is located outside of the room in the hall and an internal alarm that sounds inside the room, and both can be heard outside of the room. If there is any type of disconnection or problem, the alarm will sound until the problem is resolved and the alarm will reset itself. RT #268 stated the alarm is turned off while Resident #19 is on the nasal cannula allowing her to eat meals or take medications. RT #268 stated he was not aware of any time where Resident #19 was without oxygen for an extended period of time. Follow up interview on 10/23/25 at 9:31 A.M. with RT #268 revealed sometimes when Resident #19's daughter is present; she will turn off the external alarm while Resident #19 is eating and using the nasal cannula. When Resident #19 is finished eating, she will put her call light on, and the RT will go back to put Resident #19 back on the AVAPS system. RT #268 stated sometimes he will find the external alarm off but typically it is when Resident #19's is eating, and the daughter is present. RT #268 stated about a week ago shortly after coming on shift at 7:00 A.M. the aide notified him Resident #19 needed assistance. Upon entering the room, Resident #19 told him her oxygen hose had detached, the aide had reattached it, but the external alarm was off, and no one assisted her for a long period of time. Resident #19 was observed with her AVAP mask on, and the alarm was not sounding inside the room. RT #268 stated he was unsure how the oxygen tube became detached as he was not present when it occurred. Upon checking the external alarm, it was off, and he turned the external alarm back on. Interview on 10/23/25 at 10:00 A.M. with RT #268 revealed all the ventilators include an alarm log for reference. RT #268 proceeded to access the alarm logs for Resident #19 per manufacturer's instructions which revealed the content of all alarm events for Resident #19. Of note, RT #268 and surveyors were unable to download the complete alarm history for Resident #19 to a flash drive. RT #268 was able to scroll through the alarms and surveyor took pictures of the screen of alarms that occurred from 10/13/25 through 10/14/25. Photo evidence was obtained by surveyor's camera in RT #268's presence who confirmed the alarm events from 10/13/25 through 10/14/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of camera image #15 taken on 10/23/25 from the AVAP machine for Resident #19 revealed a patient circuit disconnect alarm on 10/14/25 at 7:29 A.M. and a resolution of the alarm at 7:40 A.M. No other alarms were observed for over one to two minutes. RT #268 verified the 7:29 A.M. alarm was resolved at 7:40 A.M. and verified Resident #19 has not had any respiratory changes or concerns and maintains optimal oxygen saturation. RT #268 stated Resident #19 can tolerate nasal cannula and room air for extended periods of time with no respiratory distress. Interview on 10/27/25 at 6:41 A.M. with CNA #218 revealed if part of the vent mask comes apart while providing care, she is trained to reattach it and then go alert respiratory, but she does not touch the mask otherwise. Interview on 10/28/25 at 7:06 A.M. with the Director of Nursing (DON) confirmed CNAs are allowed to reattach oxygen hoses if they become attached and are allowed to assist with attaching a mask if a strap is off but were not allowed to adjust any of the settings on the machine. Review of the undated facility policy titled Noninvasive Ventilation (CPAP, BiPAP, AVAP Trilogy revealed it is the policy of the facility to provide noninvasive ventilation per physician's order and current standards of practice. The policy did not list any specifics related to alarm monitoring. 2. Review of the medical record for Resident #11 revealed an admission date of 04/14/22. Diagnoses included but were not limited to chronic respiratory failure, tracheostomy, dependence upon respirator, type II diabetes with hyperglycemia, and morbid obesity. Review of the physician order dated 12/09/24 for Resident #11 revealed an order for ACVC ventilator with tidal volume with respiratory rate of 14, Positive End-Expiratory Pressure (PEEP) of five with 10 liters per minute of oxygen bleed and as needed. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #11 revealed a BIMS score of 15 of 15, which indicated intact cognition. Resident #11 was noted to require set up for eating, oral and personal hygiene and dependence upon staff for other ADL. Resident #11 was noted to require a ventilator. Review of Resident #11's care plan which was last reviewed on 09/04/25 revealed she required assistance with ADL related to respiratory failure, obstructive sleep apnea (OSA), dependence on ventilator, and obesity. Resident #11 was noted to be at risk for respiratory distress complications. Interventions listed included maintain ventilator settings as ordered, observed for changes in respiratory rate or depth. Observation on 10/20/25 at 10:50 A.M. revealed while walking on the skilled hall revealed Resident #11 (who is ventilator dependent) external ventilator alarm was turned off. RT #296 confirmed the observation and stated the alarm should not have been turned off. Review of the 01/01/25 revised facility policy called; Mechanical Ventilation revealed residents who require mechanical ventilation will be cared for in accordance with Federal, State and local guidance and with current standards of practice. Appropriate staff will provide direct monitoring of the residents on mechanical ventilation. Appropriate staff will be trained and maintain competence in the use of mechanical ventilation to include responding to alarms. (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 B. Wing	10/28/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the physician order dated 10/18/24 revealed Resident #19 required oxygen via nasal cannula at three liters/minute with all medication administrations related to diminished capacity and aspiration risk. Additionally, medication administration for Resident #19 is timed by nursing staff to be given with meals so the resident is only on the nasal cannula for the shortest amount of time and resident's preference. Review of Resident #19s care plan revised 06/12/25 revealed the resident has potential for complications related to COPD and to provide oxygen as ordered by physician and assess for difficulty breathing on exertion. Review of the camera video footage taken on 10/25/25 at 12:44 P.M. provided by Resident #19's daughter revealed Resident #19 was eating lunch without her nasal cannula on. RT #296 had removed her AVAP mask for lunch but did not transition resident to her nasal cannula with oxygen at three liters/minute per order. Resident #19 requires oxygen at all times due to her diminished lung capacity and aspiration risk and also transitions to a cannula during medication administration. Interview with RT #296 on 10/21/25 at 10:35 A.M. revealed Resident #19 remains on AVAP per preference during the day and does change to a nasal cannula for all meals and medication administration. RT #296 stated he has not observed any shortness of breath or respiratory concerns from resident who has been maintaining her oxygen saturation both on AVAP and nasal cannula. Interview with RT #268 on 10/23/25 at 9:30 A.M. also revealed Resident #19 transitions to nasal cannula with all meals. RT #268 stated the resident will call him when she wants to eat and change out the oxygen source and will call again when finished to be placed back on AVAP. Review of the facility policy titled, Oxygen Administration, revised 01/04/23, revealed oxygen is administered to resident who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. This deficiency represents non-compliance investigated under Complaint Number 2643354.

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	365825	A. Building B. Wing	10/28/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews and review of the facility policy, the facility failed to ensure hand hygiene practices were being performed consistently with accepted standards of practices to prevent the transmission of communicable diseases and infections. This had the potential to affect12 (Residents #15, #23, #24, #25, #27, #28, #29, #37, #39, #41, #44, and #46) on the south hallway who did not have functioning soap dispensers in their rooms of 48 residents reviewed for infection control. The facility census was 48. Findings include:Observation during facility tour on 10/20/25 at 10:50 A.M. with the Administrator and Director of Nursing (DON) revealed multiple resident rooms which did not have functioning soap dispensers to use for hand hygiene. These included rooms of Residents #23, #25, #27, #28, #29, #37, #39, #41, #44, and #46. In the room of Resident #15, the soap dispenser was observed to be missing off the wall. Interview with the Director of Nursing (DON) and Administrator on 10/20/25 at 10:50 A.M. confirmed the non-functional soap dispensers in resident's bathrooms. The DON and Administrator both stated that none of the staff informed them that they were not working and could not verify that all staff were performing hand hygiene as required. Multiple observations of staff from 10/20/25 through 10/28/25 revealed staff had donned gloves when removing dirty linen from resident's rooms; however, no observations were noted using the hallway alcohol sanitizer prior to entering and exiting resident rooms. It is unknown how hand hygiene was performed in the bathrooms of residents that had no functional soap dispensers. Interview with DON on 10/21/25 at 1:15 P.M. revealed she could not verify how the staff were performing hand hygiene on the south wing that had no functional soap dispensers. She re-iterated that staff did not notify her of any non-functioning soap dispensers or she would have had them fixed. The DON also stated that she does perform hand hygiene audits and education and has had no issues with compliance. Review of the facility policy titled, Enhanced Barrier Precautions, revised 07/13/22, revealed facility ensures access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). This deficiency represents non-compliance investigated under Complaint Number 2643354.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of the facility policy, the facility failed to ensure room and hall soap and sanitizer dispensers were functioning properly as required and failed to ensure the wall in Resident #14's room was in good repair. This affected 14 (Residents #2, #9, #11, #14, #15, #23, #25, #27, #28, #30, #37, #39, #41, and #46) of 48 residents reviewed for a safe and sanitary environment. The facility census was 48. Findings include:Observation during facility tour on 10/20/25 at 10:50 A.M. with the Administrator and Director of Nursing (DON) revealed multiple resident rooms which did not have functioning soap dispensers to use for hand hygiene. These included rooms of Residents #23, #25, #27, #28, #30, #37, #39, #41, #44, and #46. In the room of Resident #15, the soap dispenser was observed to be missing off the wall. Observation of the north hallway alcohol sanitization dispensers outside of Resident #2's room, the dispenser outside of Residents #9 and #11's rooms and the dispenser outside of the biohazard room revealed they were not functional for staff. Observation of Resident #14's room revealed the wall behind the head of the bed had a six-inch by eight-inch hole about 12 inches up from the floor. Plaster and drywall pieces were evident on the floor next to the fall mat on the floor. Interview on 10/20/25 at 10:55 A.M. with Resident #46 confirmed her soap had not been working for a couple days, but she uses her own sanitizer. Interview with DON and Administration on 10/20/25 at 11:56 A.M. following the environmental tour confirmed the non-functioning soap dispensers in resident's rooms as well as the wall hand alcohol-based sanitizers on the walls in the North hallway. The DON and Administrator both stated that none of the staff informed them that they were not working and could not verify that all staff were performing hand hygiene as required. The DON and Administrator also confirmed the hole in the wall for room [ROOM NUMBER] should have been cleaned up and repaired. Review of the facility policy titled, Enhanced Barrier Precautions, revised 07/13/22, revealed facility ensures access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). Policy did not speak to hand hygiene or soap dispensers. This deficiency represents non-compliance investigated under Complaint Number 2643354.