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	04/29/2026

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 0684 Level of Harm - 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, observations, resident and staff interviews, and facility policy review, the facility failed to ensure that a resident with a new rightˆleg injury received timely and thorough assessment, monitoring, treatment, and physician notification following a fallˆrelated injury. This resulted in the worsening of the untreated rightˆleg condition, which progressed to an open necrotic wound requiring hospitalization, surgical debridement, and treatment for sepsis. This affected one (Resident #18) of four residents reviewed for hospitalization. The facility census was 42.Actual harm began on 02/05/26, when Resident #18 returned from the hospital with the right lower extremity that was red, shiny, and exhibiting moderate drainage, yet the facility failed to perform a wound assessment, implement monitoring, provide treatment, or notify the physician of this significant change in condition. The facility continued to omit monitoring and followˆup from 02/06/26 through 02/10/26, during which clinical concerns increased but no documentation or treatment was provided regarding the resident's rightˆleg condition. By 02/20/26, the resident developed a weeping open wound, and by 02/21/26, a necrotic wound measuring 5.5 centimeters (cm) by 7.5 cm. On 02/24/26, the wound care team documented that the wound to the right lower extremity resulted from a fall on 02/04/26 fall, and the resident subsequently required hospitalization and surgical debridement.Findings include:Review of the medical record for Resident #18 revealed she initially admitted on [DATE] and readmitted on [DATE]. Diagnoses included chronic respiratory failure, dependence on respirator and heart failure.Review of the care plan dated 04/15/22 revealed Resident #18 required assistance for activities of daily living (ADL), was at risk for falls, had a high body mass index (BMI) related to obesity, and had potential for alteration in skin integrity with interventions including: protective and preventative care, inspect for any reddened areas during daily care, observe, monitor and report changes, observe changes in ADL ability, and adjusting assistance as needed with a goal to be free from injury. Review of the care plan revealed no actual areas of skin impairment related to the right leg were present.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively intact. She was dependent on staff for bed mobility and showers/bathing and had functional limitations to range of motion to bilateral lower extremities. She was always incontinent of bowel and bladder. Review of the weight summary dated for the last 90 days revealed Resident #18 weighed 557.8 pounds. Review of the progress note dated 02/04/26 at 8:04 A.M. revealed on 02/04/26, at approximately 5:15 A.M., Resident #18 fell during incontinent care being provided by one certified nursing assistant (CNA). Progress notes documented no visible injuries initially; however, by 12:04 P.M., the resident reported pain to the right leg. Portable xˆrays could not be completed due to pain, and she was transferred to the hospital. Hospital evaluation identified significant rightˆleg pain but no fracture.Review of the hospital paperwork dated 02/04/26 at 2:09 P.M. for Resident #18 revealed she arrived to the Emergency Department (ED) via the fire department due to a fall with a pain level of 10 out of 10 to both legs. Resident #18 revealed she had pain just below her knee to the ankle after receiving care for a fall at the facility. Resident #18's physical exam revealed the right lower extremity had tenderness of the anterior leg to the ankle and after x-rays, no fractures were found. Resident #18 was subsequently discharged back to the facility (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	with a contusion of the right lower extremity after sustaining a fall. Review of the progress note dated 02/05/26 at 3:44 A.M. the resident returned to the facility with the right leg red and shiny with moderate drainage. No wound assessment, no measurements, no documentation of size, no evaluation of drainage, no monitoring parameters, no treatment orders, and no physician notification occurred.From 02/06/26 through 02/10/26, Resident #18's progress notes reflect increasing clinical concerns but contain significant omissions. On 02/06/26, the resident reported moderate pain relieved by medication, and labs remained pending. By 02/07/26, the physician had been notified of lab results, though the documentation did not identify which labs were drawn or why they were clinically relevant. On 02/08/26, the resident was described as somewhat confused with oxygen saturations dropping to 86-89 percent on 10 liters per minute (L/min) via ventilator, later improving to 92 percent after being switched to 5 L/min via nasal cannula. On 02/09/26, continued confusion led to new orders for a urinalysis, culture and sensitivity, complete blood count (CBC) with differential, and complete metabolic panel (CMP); later that day, further labs and chest xˆrays were ordered. In the early hours of 02/10/26, repeat culture and metabolic panel labs were ordered, and later that morning the provider directed staff to hold Lasix (diuretic), insert a midline IV, place a urinary catheter, and monitor intake and output. By 02/10/26, the resident was transferred to the hospital for altered mental status and unspecified abnormal lab results and subsequently admitted to the intensive care unit (ICU) with sepsis. Throughout all documentation from 02/06/26 through 02/10/26, there is no mention of the rightˆleg redness that had been documented on 02/05/26 following the fall that occurred on 02/04/26, despite the clinical relevance of this earlier finding.Review of the hospital after visit summary dated 02/19/25 revealed Resident #18 was hospitalized for an infection in her bloodstream. The summary was absent of any information regarding the right leg.Review of the progress note dated 02/19/26 at 6:49 P.M. revealed Resident #18 returned from the hospital with some discoloration to the right lower extremity. Review of the progress note dated 02/20/26 at 6:55 A.M. revealed Resident #18 was very weak and tired, waking up for brief periods during conversations but falls right back to sleep. She had 4 plus pitting edema to bilateral lower extremities. At 6:21 P.M., staff were unable to do an adequate skin assessment due to Resident #18 being out of breath while on her side. Noted a weeping area to inner right calf, and a black weeping wound under her right calf. She refused to allow the nurse to measure or dress it. She was educated on the risk of refusal and benefits of wound dressings. She continued to refuse. The nurse practitioner (NP) #950 was notified of her refusal. NP #950 stated to attempt to put an abdominal (ABD) dressing to the site. Resident #18 continued to refuse. The facility wound care team was notified of needing a wound consult form signed. At 8:18 P.M., the nurse attempted to wake Resident #18 to take her medication and she refused. At 10:38 P.M. Resident #18 remained very tired and continued to refuse to take her medication. Review of the progress notes on 02/21/26 revealed at 1:08 A.M. Resident #18 was awake and asking for respiratory and agreed to take her medication. She continued to refuse other care. At 5:59 A.M. she was offered hygiene care and refused multiple times. She was reminded of importance of wound care in which she replied, shut up, I don't care, leave me alone. At 5:04 P.M. an area of necrotic tissue was observed to the right lower extremity measuring 5.5 cm by 7.5 cm by 0.1 cm. The area was cleansed with normal saline and a Xeroform (petroleum-based non-adherent dressing) dressing and ABD pad applied. NP #950 was notified. Review of the care plan created 02/21/26 revealed Resident #18 had an actual area of skin impairment related to right lower leg necrotic tissue. Interventions included asking resident about pain level prior to dressing change procedure, medicate if needed, maintain enhanced barrier precautions (EBP), observe for clinical changes, such as infection and/or worsening of wound, Pressure reducing mattress, pressure reducing chair cushion, refer to the dietitian to determine need/no need for dietary intervention, skin observation and document on bath/shower days, charge nurse to notify the wound nurse, physician, and family of any new areas.Review of the progress notes on 02/22/26 revealed at 1:05 A.M., Resident #18 was resting in bed, all care was completed, all medications were administered, and she denied pain. At 5:38 A.M., (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	she was upset that staff was encouraging hygiene. While staff were attempting to provide hygiene care, she asked them to leave the room. She was educated on the importance of hygiene and continued to refuse. At 5:48 P.M. and 11:58 P.M., Resident #18 had rested in bed all shift, and all medications were administered as ordered. Review of the progress notes on 02/23/26 revealed at 4:42 A.M. Resident #18 consistently made it difficult to perform hygiene by throwing her weight and arms back, swinging and resisting turning during care/ She was educated on the importance of body mechanics and told the staff, The hell with you guys. At 3:15 P.M., she declined the need for incontinent care. She was educated on the importance of routine care.Review of the wound care note dated 02/24/26 at 12:15 P.M. revealed Resident #18 had an initial consultation for wound care services due to having a recent fall out of bed (02/04/26) and being hospitalized for sepsis. Review of the wound note revealed Resident #18's wound to the right lower extremity posterior aspect resulted from the fall on 02/04/26. The wound measured 9.1 cm by 10.1 cm and the depth of the wound was unable to be determined. Treatment orders were in place, and the wound care team will follow-up weekly. Review of the progress notes dated 02/25/26 revealed a note at 7:28 A.M. stating Resident #18 was approached several times throughout the shift for hygiene (check and change), each time she refused. She was educated on the importance of being clean and dry for skin integrity. She verbalized understanding yet continued to refuse. At 12:40 A.M., Resident #18 was assessed by NP #950 for a necrotic area to the right lower extremity. Upon communication with the physician, Resident #18 received new orders to be sent to the hospital for surgical debridement. Review of the progress note dated 02/26/26 at 5:28 P.M. revealed Resident #18 was admitted to the hospital with diagnosis of sepsis and surgical debridement of the right lower extremity.During an interview on 04/19/26 at 10:25 A.M., Resident #18 stated she had fallen out of bed during care. One staff member was providing care when she was pushed out of bed, fell on the floor and injured her leg. Resident #18 said the wound was not healing, and she was now at risk of losing her leg.During an interview on 04/20/26 at 2:26 P.M., the Director of Nursing (DON), Licensed Practical Nurse (LPN) #563 and Regional Nurse #626 revealed Resident #18 had a fall while receiving incontinence care and as a result a hematoma formed that later turned into a leg wound. LPN #563 revealed Resident #18's leg wound was necrotic and had some redness and swelling and required debridement in the hospital.During an interview on 04/22/26 at 10:44 A.M. with LPN #623 stated Resident #18 complained of leg pain since her fall, and the fall caused cellulitis and ongoing issues.During an interview on 04/29/26 at 12:03 P.M., LPN #563 stated Resident #18 had no skin assessments regarding her right lower extremity, no documentation regarding follow-up care and/or notification to the physician and no new orders for treatment. The skin issue related to her right lower extremity did not present itself until 02/20/26, and after a change in condition, Resident #18 was sent to the hospital. Resident #18's hospital stay and return to the facility was related to UTI and was treated with antibiotics. Resident #18's skin issues were not the focus due to her having a history of skin concerns. LPN #563 verified after Resident #18 returned from the hospital on [DATE], a progress note indicated she had a red, swollen area with moderate drainage to her right lower extremity and the wound was not properly assessed, monitored, treated, or documented to prevent further harm. The facility's Pressure Injury Prevention and Management Policy requires staff to follow a systematic process for all skin integrity concerns, including prompt identification, assessment, documentation, treatment, monitoring, and provider notification of any skin changes. The policy mandates that licensed nurses complete fullˆbody skin assessments on admission, readmission, weekly, and as needed, and that any skin changes be immediately assessed, with measurements, wound characteristics, and findings documented in the medical record. It further requires the implementation of timely, evidenceˆbased interventions based on the wound's characteristics and the resident's risk factors, along with ongoing monitoring to evaluate healing and identify complications. The policy also directs staff to notify the physician of any new wounds, lack of healing, or complications, and to modify the care plan when a wound worsens or the resident's condition changes. These requirements (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	apply broadly to all wounds, not only pressure injuries, and establish the facility's responsibility to ensure prompt assessment, treatment, and monitoring of any newly identified skin issue.This deficiency represents non-compliance investigated under Complaint Number 2795717.

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F 0692 Level of Harm - 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, staff interviews, and policy review, the facility failed to ensure sufficient fluid intake to maintain proper hydration and health and facility failed to monitor and implement interventions to maintain proper nutritional health. This affected two (Residents #18 and #46) of four residents reviewed for nutrition. The facility census was 42.Actual harm occurred on 10/31/25 when Resident #46 was transferred to the hospital for treatment of severe dehydrationˆrelated complications due to the facility's failure to adequately monitor and assess his hydration status, failure to ensure tubeˆfeeding and flush orders were written correctly and implemented as intended, and failure to respond appropriately to his documented change in condition.Findings include:1. Record review revealed Resident #46 was admitted on [DATE]. Diagnoses included respiratory failure, hypertension, and dysphagia (difficulty swallowing). Resident #46 discharged from the facility on 10/31/25.Review of the care plan dated 11/07/24 revealed Resident #46 was at risk for alteration in nutrition and/or hydration related to total dependence on enteral tube feed to meet nutrition and hydration needs with interventions including monitoring for signs and symptoms of dehydration, reviewing labs as ordered and requesting dietary interventions.Review of the progress note dated 07/04/25 at 10:00 A.M. revealed Resident #46 received nothing by mouth (NPO) with a feeding tube, had a significant weight loss and was currently on Isosource 1.5 mL at 70 mL every 22 hours with 200 mL free water flush every four hours. Review of the progress note revealed Resident #46's current order was discontinued and new orders for weight and nutrition monitoring and Isosource 1.5 mL at 70 mL with 55 mL free water flush were implemented.Review of the progress note dated 07/04/25 at 10:13 A.M. revealed Resident #46 had a new intervention of weekly weights to determine if intervention was necessary. Review of the physician orders dated 07/04/25 revealed an enteral feed order for Isosource 1.5 milliliters (mL) at 70 mL per hour, off two hours for activities of daily living (ADL) care and a free water flush of 55 mL every 22 hours. Review of the order revealed an end date of 11/03/25.Review of the nutrition assessment dated [DATE] revealed Resident #46 was on an NPO diet with tube feed. Review of the tube feed order revealed Resident #46 was to receive Isosource 1.5 mL with 55 mL free water flush every 22 hours.Review of the Medication Administration Record (MAR) and Treatment Administration Records (TAR) dated July, August, September and October 2025 revealed Resident #46 received enteral feed order for Isosource 1.5 mL at 70 mL with 55 mL free water flush every 22 hours as scheduled. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 was cognitively intact and was independent in making decisions regarding tasks of daily life. Resident #46 required some assistance from staff with ADL.Review of the progress note dated 10/31/25 at 10:50 A.M. revealed Resident #46 had a moist cough and was somewhat lethargic during medication administration. Resident #46 required increased verbal stimulation to arouse but reported he was tired and wanted to stay in bed. Resident #46 was given Tylenol (analgesic) and was awaiting further instruction.Review of the progress note dated 10/31/25 at 10:50 A.M. revealed Resident #46 had a change in condition and was transferred to the ER. Review of the follow-up progress note dated 10/31/25 at 2:24 P.M. revealed Resident #46 received new orders for blood work, an urgent chest x-ray, oxygen if needed, Tylenol every six hours for comfort, Augmentin (antibiotic) twice daily for seven days, and Duoneb (inhalation solution to treat bronchospasms) breathing treatments as needed for shortness of breath. Resident #46 also received orders to be closely monitored with vital signs each shift, given extra fluids through the intravenous (IV) line, starting with a bolus of 0.9 percent Normal Saline (NS) and then a continuous infusion and a one-time water bolus through the feeding tube.Review of the progress note dated 10/31/25 at 3:15 P.M. revealed Resident #46 had a reported critical sodium level of 123 millimoles per liter (mmol/L) (normal is between 135 and 145 mmol/L) and was being transferred to the hospital via emergency medical services (EMS). Review of the weight summary dated July, August, September 2025 revealed Resident #46 had monthly weights, but (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	no weekly weights as requested by Registered Dietitian (RD) #630. Review of the weight summary revealed no other documented weights for the duration of Resident #46's stay. Review of the progress note documented by Registered Nurse (RN) #631, dated 10/31/25 revealed Resident #46 had an acute visit after being found with a fever of 101.2 degrees Fahrenheit (F) and tachycardia (increased heart rate) of 104 beats per minute (bpm). Resident #46 had no signs or symptoms of a urinary tract infection (UTI) and had dry mucous membranes. Resident #46 was resting in bed, lethargic, tired, and per staff was normally conversational. Resident #46 received initial orders for blood work, an urgent chest x-ray, oxygen if needed, Tylenol every six hours for comfort, Augmentin twice daily for seven days, and Duoneb breathing treatments as needed for shortness of breath. Resident #46 also received orders to be closely monitored with vital signs each shift, given extra fluids both through the IV and a one-time water bolus through the feeding tube. Resident #46 had a sodium level of 173 mmol/L and was to be sent to the ER.Review of the hospital laboratory results dated [DATE] revealed Resident #46 had NA levels of 173, BUN levels of 58 milligrams per deciliter (mg/dL) (normal is 8 to 24 mg/dL in adult males), Creatinine levels of 1.3 mg/dL (normal is 0.7 to 1.3 mg/dL), and Glomerular Filtration Rate (GFR) levels of 56 milliliters per minute (mL/min) (normal is above 90 mL/min).Review of the hospital paperwork dated 11/03/25 revealed Resident #46 was admitted to the hospital with hypernatremia from free water deficit, acute kidney infection from dehydration and toxic metabolic encephalopathy, multifactorial etiology, significantly due to dehydration and hypernatremia. Resident #46 was transferred to the hospital for lethargy and abnormal labs with high sodium levels above 170, which was confirmed upon arrival.During an interview on 04/20/26 at 2:26 P.M., Assistant Director of Nursing (ADON) #563 stated Resident #46 went to the hospital due to being septic and dehydrated.During an interview on 04/27/26 at 9:22 A.M., Hospital Liaison/RN #951 stated Resident #46 arrived at the hospital without any paperwork, very high levels of sodium and was severely dehydrated. After hospital blood work, Resident #46's sodium level was 173. She spoke with Licensed Practical Nurse (LPN) #612 and requested copies of recent labs from the facility, but was informed there were no copies of recent labs to provide.During an interview on 04/27/26 at 9:59 A.M., ADON #563 stated Resident #46 had a noticeable change in condition, RN #631 was contacted, and new orders were received for labs, fluids and antibiotics. ADON #563 revealed Resident #46 he had critical labs and needed to be sent to the ER and was subsequently admitted . ADON #563 reviewed the tube feeding order and stated she was not sure why the flush order was written to be done every 22 hours. She stated there was no documentation that indicated staff were monitoring, inputting formulas correctly, or following up with RD #630 for confirmation regarding Resident #46 tube feed. During an interview on 04/27/26 at 10:36 A.M., LPN #612 stated she was the night nurse, but she could not recall anything related to Resident #46's transfer to the hospital.During an interview on 04/27/26 at 1:35 P.M., Regional Nurse #626 stated she was not sure if Resident #46's hospitalization was the cause of free water deficit or not getting enough water from the tube feed. She confirmed there were no tube feed machines that could run feed and flushes at the same time. ADON #563, who was present for the interview, stated multiple bags can hang simultaneously but could not run at the same time because different time intervals would need to be entered into the machine to indicate when to start the feed and when to start the flush. During an interview on 04/27/26 at 2:23 P.M., RD #630 stated she changed Resident #46's flush from bolus to having it with the tube feed but could not remember why. She did not know what type of feeding tube pump Resident #46 utilized. After reviewing Resident #46's record, RD #630 could not provide any information regarding why the flush orders were not clarified to prevent too little flushing, the risk of tube clogging, dehydration or excess fluid. Review of the facility document titled Hydration, dated 05/20/22, revealed the facility had a policy in place to provide sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. Further review of the policy revealed the dietician would gather and use data from the nutritional assessment and ongoing monitoring to determine if fluid intake was adequate to meet hydration needs. Review of the document revealed the (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	facility did not implement the policy.Review of the facility document titled Appropriate Use of Feeding Tubes, revised 06/04/23, revealed the facility had a policy in place to ensure that a resident acceptable parameter of nutritional and hydration status was maintained. Review of the document revealed the facility did not implement the policy.2. Record review revealed Resident #18 was admitted on [DATE]. Diagnoses included chronic respiratory failure, dependence on respirator (ventilator status), and heart failure.Review of the care plan dated 04/15/22 revealed Resident #18 required assistance for ADL, was at risk for falls, and had a high body mass index (BMI) related to obesity, with interventions including observing, monitoring and reporting changes, assisting with ADL, following physician orders and monitoring weights.Review of the nutrition and hydration assessment dated [DATE] revealed Resident #18 weighed 399 pounds, was on a low concentrated sweets diet with regular texture with interventions that included weight monitoring per physician orders. Resident #18's skin was intact with no new recommendations. Review of the nutrition and hydration assessment dated [DATE] revealed Resident #18 weighed 399 pounds, was on a low concentrated sweets diet with regular texture with interventions that included weight monitoring per physician orders. Resident #18 skin was intact with no new recommendations. Review of the assessment revealed it was dated 10/31/25 and identical to the assessment completed approximately four months prior. Review of the assessment revealed it was dated 10/31/25 but was not locked until 01/23/26.Review of the progress note dated 02/20/26 at 11:20 A.M. revealed resident #18 returned to the facility after being hospitalized . Resident #18 weighed 399 pounds prior to her hospitalization and had a current weight of 573 pounds. s. Resident #18 received no new recommendations and to continue with weight monitoring per physician orders and report any significant changes.Review of the nutrition and hydration evaluation dated 04/03/26 revealed Resident #18 weighed 558 pounds, was considered morbidly obese, had a regular diet with regular textures with interventions that included strict weight monitoring, monitoring weights per physician orders and notify physician of any significant weight changes.Review of the weight summary revealed Resident #18 weighed 381 pounds on 07/02/25; 398.9 pounds on 10/23/25; and 557.8 pounds on 04/02/26. Review of the weight summary revealed Resident #18 was not being weighed weekly, bi-weekly, or monthly.Review of the MDS assessment dated [DATE] revealed Resident #18 was cognitively intact and was dependent on staff for ADL. She had no behavior problems and did not reject care.Review of the current physician orders, completed and discontinued, revealed no orders for weight monitoring.Review of the progress notes dated 04/10/26 at 9:05 A.M. revealed Resident #18 had a nutrition review related to significant weight change. Resident #18 had a most recent weight of 558 pounds with a BMI of 90, which was morbidly obese. Resident #18 had gained 159 pounds over five months, which was unplanned and undesired. Resident #18 received new orders for daily weights for a week to confirm weight gain.Review of the medical record for Resident #18 revealed no documentation related to physician notification, weight orders, weight monitoring, or in-depth assessments of Resident #18 nutritional status related to significant weight gain. Review of the medical record revealed Resident #18 refused being weighed twice with no other attempts documented.During an interview on 04/21/26 at 12:19 P.M., Certified Nurse Assistant (CNA) #570 stated staff CNAs were responsible for weighing residents according to their orders. Most residents were weighed monthly, unless informed by the nurse to do it more often. CNA #570 stated Resident #18 was not weighed often, and she could not remember the last time she was weighed. Resident #18 was not on the list of residents to be weighed daily, weekly, or monthly.During an interview on 04/21/26 at 12:21 P.M., LPN #513 stated CNAs were responsible for weighing residents and reporting the weights to the nurses. Residents were weighed according to their orders and personal care needs. Some residents were on daily, weekly, or monthly weights. LPN #513 stated Resident #18 was morbidly obese and was nutritional risk due to her size, eating habits, medical diagnoses, and skin issues. RD #630 followed Resident #18 to ensure she remained at baseline with no decline in health. LPN #513 verified there were no orders for daily, weekly, or monthly weights.During an interview on 04/22/26 at 11:43 A.M., RD #630 stated Resident #18 was (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	morbidly obese and had a significant weight increase and was recently placed on fluid restrictions. RD #630 stated she was not sure why Resident #18 was placed on fluid restrictions, but she assumed it was due to retaining water. RD #630stated she was only provided updates on Friday's during risk meetings. She was monitoring Resident #18's weights weekly and was aware of her weight gain of over 100 pounds. RD #630 verified there were no orders for daily, weekly, or monthly weights and no ongoing documented refusals. RD #630 also revealed Resident #18's January 2026 assessment was the most recent weight obtained but could not identify where the weight came from since the last weight documented was from October 2025. RD #630 stated she did not have a new weight for Resident #18, so she reused a previous documented weight. RD #630 revealed she had not assessed Resident #18 in person, therefore her documented assessments were only from information gathered from risk meetings and the medical record. EMR. RD #630 revealed she used the information from previous assessments and other areas of Resident #18 medical record to complete nutritional documentation. RD #630 acknowledged that the information documented in Resident #18 medical record did not accurately reflect Resident #18's current nutritional health status. This deficiency represents non-compliance investigated under Complaint Numbers 2668853 and 1320283 (OH00166923).

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Oaks	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, policy review, and staff interviews, the facility failed to ensure that kitchen and nursing unit refrigerators were maintained in a clean and sanitary condition. This failure had the potential to affect all residents except nine identified by the facility as receiving nothing by mouth (Residents #4, #5, #7, #8, #15, #27, #28, #37, and #38). The facility census was 42. Findings include:During a kitchen tour on 04/19/26 from 10:16 A.M. to 10:36 A.M. with Dietary Manager (DM) #556, the dry storage room floor beneath racks on the right side was observed to be dirty with stains and debris. Beneath the rack holding thickened beverage cartons, a large brownish stain was noted. Across from this area, two large storage containers-one containing a box of sugar and the other a bag of flour-were observed to be dirty both inside and outside, with various debris present. In the walk-in freezer, a large light pink frozen substance was noted on the floor near the door. The bottom of the blue ice machine scoop container contained a moderate amount of black residue. DM #556 verified all observations at the time of the tour.Review of the undated policy titled Sanitary Conditions indicated that all equipment must be maintained in a clean and sanitary manner. The policy further states that non-refrigerated food items must be stored above the floor on shelves, racks, or dollies that allow for proper cleaning and airflow, and that ice machine containers and scoops are to be sanitized through the dish machine at the end of each day.2. On 04/21/26 at 9:00 A.M., an observation of a nursing unit refrigerator with Regional Dietary Manager (RDM) #900 revealed sticky clear shelves on the inside door. A strand of hair was observed beneath the second clear shelf, and a dried orangeˆreddish splatter was noted running down the inside of the refrigerator door. RDM #900 verified these findings at the time of the observation. Review of the diet order list report dated 04/19/26 revealed nine residents (#4, #5, #7, #8, #15, #27, #28, #37, and #38) who received nothing by mouth. Review of the Resident and Snack Refrigerators policy, revised 10/01/24, revealed that unit refrigerators are to be cleaned weekly by nursing or housekeeping staff, with outˆofˆcompliance food items discarded. The policy also states that nursing staff are responsible for cleaning spills as needed or contacting housekeeping.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews, staff interviews, facility policy review, the facility failed to ensure that residents' advance directives were accurately completed, signed by a practitioner when required, and consistently documented in the medical record. This failure resulted in inaccurate, missing, or conflicting code status information for four residents (Residents #4, #17, #18, and #28) of four residents reviewed for advance directives, creating the potential for staff to provide care inconsistent with the residents' expressed wishes. The facility census was 42. Findings include:1. Review of Resident #4's medical record revealed an admission date of [DATE] with diagnoses of vascular dementia, obstructive pulmonary disease, aphasia following unspecified cerebrovascular disease, and chronic kidney disease (CKD) Stage III. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 09 out of 15, indicating Resident #4 had moderate cognitive impairment. Review of Resident #4's medical record (hard chart) and electronic medical record (EMR) revealed no code status. Interview with Licensed Practical Nurse (LPN) #587 on [DATE] at 3:10 P.M. revealed no code status in Resident #4's medical record or EMR. 2. Review of Resident #17's medical record revealed an admission date [DATE] with diagnoses of bilateral primary osteoarthritis of hip, morbid obesity, and type II diabetes mellitus with hyperglycemia. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #17 was cognitively intact. Review of Resident #17's medical record and EMR revealed no code status. Interview with LPN #587 on [DATE] at 3:15 P.M. confirmed Resident #17 had no code status in their medical chart or EMR. 3. Review of the medical record for Resident #18 revealed she was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, dependence on respirator (ventilator status), and heart failure. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #18 had a BIMS score of 15 out of 15, indicating she was alert and oriented to person, place, and time. Resident #18 was dependent on staff for activities of daily living (ADL). Review of the physician order located within the hard medical chart dated [DATE], revealed an advance directive of Do Not Resuscitate-Comfort Care Arrest (DNR-CCA), that indicated Resident #18 wanted full life-saving treatments provided until her heart or breathing stopped. Resident #18 elected to have comfort care to ease pain and suffering with no Cardiopulmonary Resuscitation (CPR) or resuscitation once arrest occurred. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated [DATE] revealed Resident #18 chose to have an advance directive of DNR-CCA, and no CPR measures would not be attempted during cardiac arrest. Review of the physician orders located in Point Click Care (PCC) within the EMR, dated [DATE] revealed an advance directive of Full Code, that indicated Resident #18 requested all life-saving measures were to be used if she was to stop breathing or her heart stopped. Interview on [DATE] at 4:16 P.M. with Regional Nurse #626 during review of Resident #18 EMR and hard medical chart revealed Resident #18 advance directives did not match and did not clearly indicate medical treatment preferences if she was to become incapacitated. Regional Nurse #626 verified the above findings at the time of the interview. 4. Record review of Resident #28 revealed he was admitted [DATE] with diagnoses including respiratory failure, paraplegia, and hypoxic encephalopathy. He had a DNR order dated [DATE]. Record review of his paper chart revealed it was dated [DATE] and had no signature from any physician or other practitioner. Interview with LPN #587 on [DATE] at 11:29 A.M. confirmed the above finding. Review of the facility document titled Resident's Rights Regarding Treatment and Advance Directives, revised [DATE], revealed the facility had a policy in place that residents had a right to formulate an advance directive and it would be communicated with staff and documented in the medical chart. Review of the document revealed the facility did not implement the policy.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff spoke to Resident #41 respectfully using her preferred name. This affected one (Resident #41) of five residents reviewed for dignity. The facility census was 42.Findings include:Record review of Resident #41 revealed she was admitted [DATE] and had diagnoses including dementia, anxiety disorder, and chronic respiratory failure. Her Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had mild or no cognitive impairment.Observation of a video dated 01/22/26 revealed an unseen staff member call Resident #41 by her last name during care.Record review of emails sent by the daughter of Resident #41 to facility staff and the Ohio Department of Health revealed that the emails were directed to verified email addresses belonging to administrative staff. An email dated 02/09/26 stated that Certified Nurse Aide (CNA) #576 called Resident #41 by her last name only. The daughter indicated this was disrespectful, as she believed elders should not be addressed solely by their last name. A subsequent email dated 02/18/26 reported that an unidentified aide continued to address Resident #41 in the same manner. The emails also alleged that staff yelled at Resident #41 and spoke to her as if she were a child.Interview with Resident #41 on 04/19/26 at 10:08 A.M. revealed workers yelled at her often and some were ?very nasty.'Interview with the Administrator, Director of Nursing, Assistant Director of Nursing #563, and Regional Nurse #626 on 04/20/26 at 2:26 P.M. revealed they denied knowledge of the above-noted concerns with the resident being yelled at or of concerns for the resident not being called by her preferred name.Interview with Licensed Practical Nurse (LPN) #543 on 04/22/26 at 11:14 A.M. revealed she sometimes called Resident #41 by her last name and denied knowledge of this not being her preference.Interview with Certified Nursing Assistant (CNA) #576 on 04/22/26 at 1:56 P.M. revealed she called Resident #41 by her last name and denied knowledge of this not to being her preference. She denied ever mistreating or yelling at the resident.Interview with Regional Nurse #626 on 04/27/26 at 1:09 P.M. confirmed the video showed a staff member addressing Resident #41 by her last name.Interview with Resident #41 on 04/28/26 at 8:49 A.M. revealed she preferred to be called by her first name. She said staff sometimes called her by her last name, which she felt was rude and disrespectful.Record review of the resident concern log for the past year revealed no documented concerns regarding Resident #41.This deficiency represents noncompliance investigated under Master Complaint Number 2961312 and Complaint Numbers 2726820, 2623912, and 2606964.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews and policy review, the facility failed to reasonably accommodate Resident #41's longstanding (since June 2024), care-planned preference to maintain an electronic monitoring device in her room. The facility failed to support continuation of the device in accordance with the residents' rights, preference and care plan. This affected one resident (41) of one reviewed for personal property. The facility census was 42.Findings include:Record review revealed Resident #41 was admitted to the facility on [DATE]. Resident #41 resided in a private room with no roommate. Review of a care plan dated 06/12/24 revealed the resident's preference to use electronic monitoring in her room. The care plan specifically instructed staff not to obstruct, tamper with, or destroy any recording devices. Review of a care conference note dated 12/02/25 revealed Admin discussed alternate placement with resident and POA. At this time facility cannot meet resident's needs and POA is non-compliant with camera policy. Facility will assist POA and resident with finding alternative placement. Daughter is excessive with emails (i.e sending at all hours i.e. 11:49 pm multiple times a day) encouraged daughter to go directly to nursing when she is in facility. The care conference notes failed to contain any additional information related to how the resident's daughter was non-compliant with the facility camera policy and/or any measures taken to ensure the resident's right to use an electronic monitoring device in her room was honored. A progress note dated 03/12/26 revealed the Administrator notified the resident's daughter on 03/09/26 the camera had been removed for noncompliance with policy, and the family retrieved the camera on 03/12/26. Information provided from Resident #41's daughter during the investigation revealed this camera was the third camera she had purchased for use in the facility since the resident's admission as the two prior camera devices had been damaged by facility staff. The daughter indicated this most recent camera (that had been removed by the Administrator on 03/09/26) had been in place since 06/26/25. During the onsite survey, the facility provided no documented evidence of any new or immediate safety risk justifying the abrupt removal of the camera, nor any written notice or progressive steps to warrant the removal of the device between 06/2025 and 03/2026). Observation of Resident #41's room on 04/19/26 at 10:06 A.M. revealed the resident had a posting on the door identifying there was electronic recording in the room.Interview with Resident #41 on 04/19/26 at 10:08 A.M. revealed she had a camera on the drawers at the foot of her bed until a few weeks ago, when staff removed it against her wishes. Observation revealed the resident had no obvious camera in the room, including on the drawers at the foot of her bed. Resident #41 was the only resident residing in the room.Interview with the Administrator on 04/19/26 at 4:56 P.M. revealed he removed Resident #41's camera because it violated facility policy, stating it could be remotely moved. The Administrator denied any Wi-Fi issues in Resident #41's room and explained the camera's noncompliance had been discussed with the family and ombudsman numerous times over the last year before the facility ultimately removed it. The Administrator maintained the camera was noncompliant due to its ability to pan and be remotely controlled and further stated the resident's daughter had spoken or yelled at staff through the cameraInterview with Ombudsman #700 on 04/20/26 at 1:16 P.M. revealed the facility reported Resident #41's camera could follow people when it moved around the room, but Resident #41's daughter said it did not do this. The facility communicated a new camera could be put in the room from a list they said they would provide the daughter; however, Ombudsman #700 was not sure if the list had been provided as of this date. Interview with Ombudsman Team Lead #701 on 04/20/26 at 1:44 P.M. revealed the family of Resident #41 wanted the previous camera (that had been removed by the Administrator on 03/09/26) back in the room as the daughter was refusing to pay for a fourth camera. The Ombudsman Team Lead revealed it was her understanding the facility justified the removal of the camera because the camera could move and because Resident #41's daughter spoke to staff through the camera.Interview with the Administrator, Director of Nursing, Assistant (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing #563, and Regional Nurse #626 on 04/20/26 at 2:26 P.M. verified the camera that had been in Resident #41's room since 06/2025 had been removed by the Administrator in 03/2026. The administrative staff revealed they had determined Resident #41's camera could pan the room, and they did not allow cameras that could do that. The Administrator removed the camera, and staff returned it to the family. The Administrator said the daughter could place a new camera in the room but needed to go through him first to ensure compliance with facility policy. He said the camera should have a fixed position, and the daughter should not be able to speak through it into the room.During an interview with Resident #41's daughter on 04/21/26 at 4:07 P.M. the daughter showed the surveyor the camera that had been removed from Resident #41's room. Observation of the camera revealed no evidence the camera had independent locomotion; however, it could rotate without direct physical manipulation. Resident #41's daughter showed the surveyor an app on her phone demonstrating the camera could be set to a fixed position. She said that Wi-Fi in the resident's room often went out, and when it did the camera reset its' settings, and she had to turn off its mobility again. The daughter reported she had numerous recorded incidents of staff yelling at or mistreating the resident and staff often blocking the camera by placing towels over it or standing directly in front of it that had been lost because the SD card from the camera was missing when the facility returned the device to her. During the interview, Resident #41's daughter revealed at the 08/28/25 care conference, she attempted to demonstrate the device's fixedˆposition capability, but she stated the Administrator refused to review it. She then shared she had sent emails to facility administrative staff explaining the camera's functionality and need to be reset after Wi-Fi outages to keep it in a fixed, which the facility failed to respond to. Resident #41's daughter revealed she stopped sending emails after a 12/02/25 care plan meeting because she stated during this meeting she was threatened with a 30-day discharge notice for sending excessive emails. Record review revealed the facility provided no documented evidence explaining the loss of the memory card or demonstrating attempts to investigate or recover the resident's memory card from the camera. Review of emails sent by Resident #41's daughter from [NAME] 2025 through March 2026 (including on 08/12/25, 10/02/25, 10/13/25, 11/15/25, 03/12/26, 03/17/26, and 03/25/26) to verified email addresses of facility staff revealed communication voicing concerns of persistent Wiˆ Fi failures within the facility causing the camera to reboot and rotate automatically. The emails noted the camera device was always set to a fixed position and never placed on motion tracking. The emails included repeated requests for maintenance intervention of the facility Wi-Fi system to address connectivity issues which had been ongoing (per the daughter) for over a year.Review of the facility's electronic monitoring policy revealed it required cameras to be fixedˆposition but contained no prohibition against twoˆway audio, despite the Administrator citing audio use as a reason for removal. This discrepancy demonstrated the facility relied on unwritten or inconsistently applied expectations when removing the resident's property.Review of the facility's concern log from March 2025 to March 2026 revealed no entries regarding camera compliance issues, despite the Administrator's assertion the matter had been discussed numerous times over the last year. The absence of such documentation beyond care conference minutes (from the meeting held on 12/02/25 which focused on the volume of the daughter's emails rather than any verified cameraˆrelated noncompliance and contained no evidence of progressive steps or efforts to reconcile the issue) contradicts the facility's claim of ongoing issues and undermines justification for immediate removal of the resident's property.This deficiency represents noncompliance investigated under Complaint Number 2804759 and Complaint Number 2726820.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on record review, interviews, and facility policy review, the facility failed to ensure that a resident's medical records request was honored in accordance with policy. This failure affected one (Resident #41) of one resident reviewed for records requests. The facility census was 42Findings include:Record review showed that the daughter of Resident #41 sent emails on 03/15/26 and 04/25/26 to verified facility email addresses for the Assistant Director of Nursing (ADON) #563, Social Worker #574, and carbon copied (cc) the Long-Term Care Ombudsman requesting the resident's medical records. She also asked to be sent any required forms needed to complete the requestDuring interview on 04/27/26 at 1:47 P.M., ADON #563 confirmed these emails were sent but stated she did not recall seeing the records request.During a separate interview at the same time, Social Worker #574 reported that she began employment on 03/16/26, one day after the first email was sent. Although she used the same social worker email address to which the request was sent, she stated she did not review emails that predated her start date. She denied knowledge of any records request and said such requests would go through the AdministratorAn interview with the Administrator on 04/27/26 at 4:35 P.M. revealed he was not aware that Resident #41's family had made a records request, but he confirmed that an email dated 03/15/26 requesting records had been sent to facility management addressesReview of the facility's medical records release policy dated 06/01/24 revealed that all resident record requests must be referred to the Administrator. The policy directs the facility to review each request, verify the requesting party's access rights, request further information if needed, and notify the relevant office to ensure the request is completed.This deficiency represents noncompliance investigated under Complaint Number 2726820.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to uphold its responsibility to protect residents' rights to receive care in a manner that maintains their dignity, autonomy, and personal property. This affected one (Resident #41) of one resident reviewed for personal property. The facility census was 42.Findings include:Record review of Resident #41 revealed she was admitted [DATE] with diagnoses including dementia, anxiety disorder, and chronic respiratory failure. Her Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had mild or no cognitive impairment. Her progress notes revealed no documentation of any missing SD card, socks, or cord, or of any broken phones or cameras.Review of an email sent to the verified email address of the Director of Nursing (DON), Assistant Director of Nursing (ADON) #563 and Ohio Department of Health (ODH) email addresses by the daughter of Resident #41 on 03/19/26 revealed the daughter reported a set of cabin socks given as a Christmas present were stolen from her room on 03/17/26. She also said she previously reported two cameras, and a phone were broken by staff with no reimbursement.Review of an email sent to the verified email address of the ombudsman's office by the daughter of Resident #41 on 03/14/26 revealed she reported a missing camera and SD card.Review of an email from Regional Nurse #626 dated 04/21/26 revealed the facility did not have an inventory list for Resident #41's possessions.Review of the Ohio Department of Health Certification and Licensure website revealed no alleged misappropriation events were reported by the facility within the last six months.Interview with Resident #41 on 04/19/26 at 10:08 A.M. revealed she had cameras that were missing. She also said staff took the cord off her [NAME] music device last week and now it was unusable. She could not say if she notified the staff but said her daughter probably did so.Interview with Ombudsman #700 on 04/20/26 at 1:16 P.M. revealed her office was notified of a missing SD card for Resident #41's camera in March 2026. They went to the facility to follow up on the concern and staff denied knowledge of the missing SD card.Interview with the Administrator, DON, ADON #563, and Regional Nurse #626 on 04/20/26 at 2:26 P.M. revealed the Administrator removed the camera from Resident #41's room and said there was no SD card present at that time. He said staff had not been told of any missing items including a missing cord, socks, or SD card.Interview with Resident #41's daughter on 04/21/26 at 4:07 P.M. revealed she said staff removed a camera from the resident bedside and returned it to her without the SD card she purchased to store data in it. Staff had also broken two cameras since June 2026 and broke the resident's phone by dropping it.Interview with Regional Nurse #626 on 04/29/26 at 3:30 P.M. confirmed the facility did not have any recent ?soft file' documenting response to concerns for the family of Resident #41 which may not be logged in her official medical records.Record review of the resident concern log from March 2025 to March 2026 revealed no concerns related to Resident #41.This deficiency represents noncompliance investigated under Complaint Numbers 2726820, 2639150, 2623912, and 2606964.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Ohio Department of Health (ODH) Certification and Licensure website, facility policy review, and interviews, the facility failed to follow established policies for responding to allegations of abuse, neglect, and misappropriation. This affected one (Resident #41) of two residents reviewed for abuse. The facility census was 42.Findings include: Record review of Resident #41 revealed she was admitted [DATE] with diagnoses including dementia, anxiety disorder, and chronic respiratory failure. Her Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had mild or no cognitive impairment. Review of her progress notes revealed no evidence of documented abuse or misappropriation allegations in 2026. She was hospitalized [DATE] for sepsis and returned to the facility 03/06/26.Record review of emails sent by the daughter of Resident #41 to verified email addresses facility staff and ODH revealed the following allegations regarding the care of Resident #41:- An email dated 01/24/26 said Licensed Practical Nurse (LPN) #533 gave Tramadol (opioid pain medication) doses too close together and behaved with animosity and hatred, saying ?ridiculous things' about the resident and daughter.- An email dated 02/02/26 said LPN #533 intimidated Resident #41, who was afraid to be alone with her.- An email dated 02/05/26 said LPN #533 did not give medications as ordered and falsely said the resident refused care. Resident #41 also called for incontinence care and had her light turned off with no response for several hours.- An email dated 02/09/26 said Certified Nurse Aide (CNA) #576 disrespected Resident #41's personal belongings daily and spoke to her like a three-year old.- An email dated 02/18/26 said an unclarified aide enacted verbal abuse by continually yelling at Resident #41.- An email dated 03/19/26 said a set of cabin socks were stolen from Resident #41.Review of an email sent to the ombudsman's office by the daughter of Resident #41 on 03/14/26 revealed she reported a missing camera and SD card.Record review of the ODH Certification and Licensure website revealed the only self-reported incident (SRI) involving Resident #41 within the last six months was SRI #271831 dated 03/09/26, which involved an allegation of neglect and mistreatment by LPN #533 and CNA #576.Interview with Resident #41 on 04/19/26 at 10:08 A.M. revealed workers yelled at her quite often and aides were very nasty. She could not remember the specifics of who or what was involved with these events. She also said staff took the cord from her Bluetooth radio last week, rendering it unusable.Interview with Ombudsman #700 on 04/20/26 at 1:16 P.M. revealed her office was notified of a missing SD card for Resident #41's camera in March 2026. They went to the facility to follow up on the concern and staff denied knowledge of the missing SD card.Interview with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) #563, and Regional Nurse #626 on 04/20/26 at 2:26 P.M. revealed they denied knowledge of all abuse, neglect, and misappropriation allegations in the above noted emails.Interview with the daughter of Resident #41 on 04/21/26 at 4:07 P.M. revealed she believed staff stole the SD card from the camera the facility removed from Resident #41's room, which contained footage of staff screaming at the resident.Record review of SRI #271831 dated 03/09/26 revealed staff were alleged to have spoken to the resident in a loud, abrasive manner. The report identified concerns of mistreatment with no specifics noted. There was no noted interview or attempted interview with the daughter, and the only noted interview with Resident #41 was the same questionnaire form other residents received wherein pre-written answers were circled indicating she felt safe and had no concerns with neglect or mistreatment. There was also no documented attempt to request footage from a monitoring camera, which was identified in progress notes to be in the resident's room until the facility removed it on 03/12/26.The surveyor confirmed the above findings in the SRI with Regional Nurse #626 on 04/22/26 at 2:34 P.M.Following the above interview, the facility furnished an email from the daughter of Resident #41 dated 03/07/26. In it, the daughter said the two alleged perpetrators were not allowed to go in Resident #41's room given what took place on February 18 and for the management to please be aware there is video documenting everything that went on in (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	04/29/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her room that day. She said Resident #41 told her she was terrified of the alleged perpetrators. She said she lost track of how many times she reported the alleged perpetrators via emails. She said that LPN #533 publicly called Resident #41 a pain in the [expletive] and was negligent in giving care and medications. She also said her concerns kept being swept under the carpet.Following the above interview, the facility furnished a call log allegedly demonstrating they made efforts to contact the daughter of Resident #41 for interview during the SRI investigation. The log showed one outbound call to the daughter's phone number labeled no answer, two labeled answered, and one documented inbound call from the daughter. There was no record of the results of these calls.Interview with the Administrator on 04/22/26 at 3:16 P.M. revealed he said Resident #41 did not know what he was talking about when he spoke with her for the SRI investigation. He said the resident's daughter never answers her phone and never calls back when he tries to reach out regarding any of her concerns.Record review of the resident concern log for the past year revealed no documented concerns regarding Resident #41.Record review of the facility's undated electronic monitoring policy revealed the facility would not independently access recordings but would request the recordings if needed for an abuse or other investigation.Record review of the facility's abuse policy dated 01/01/24 revealed the facility was to immediately investigate reports of abuse, neglect, or exploitation. This investigation was to include interviewing all involved persons and to be focused on determining if abuse occurred. All alleged violations were to be reported to the state agency within two hours if the allegations involved abuse and 24 hours if they did not.This deficiency represents noncompliance investigated under Master Complaint Number 2961312, Complaint Numbers 2726820, 2623912 and 2606964.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the Ohio Department of Health (ODH) Certification and Licensure website, facility policy review, the facility failed to report alleged abuse, neglect, and misappropriation events to State Agency as required. This affected one (Resident #41) of two residents reviewed for abuse. The facility census was 42.Findings include: Record review of Resident #41 revealed she was admitted [DATE] with diagnoses including dementia, anxiety disorder, and chronic respiratory failure. Her Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had mild or no cognitive impairment. Review of her progress notes revealed no evidence of documented abuse or misappropriation allegations in 2026. She was hospitalized [DATE] for sepsis and returned to the facility 03/06/26.Record review of emails sent by the daughter of Resident #41 to verified email addresses of facility staff and ODH revealed the following allegations regarding the care of Resident #41:- An email dated 01/24/26 said Licensed Practical Nurse (LPN) #533 gave Tramadol (opioid pain medication) doses too close together and behaved with animosity and hatred, saying ?ridiculous things' about the resident and daughter.- An email dated 02/02/26 said LPN #533 intimidated Resident #41, who was afraid to be alone with her.- An email dated 02/05/26 said LPN #533 did not give medications as ordered and falsely said the resident refused care. Resident #41 also called for incontinence care and had her light turned off with no response for several hours.- An email dated 02/09/26 said Certified Nurse Aide (CNA) #576 disrespected Resident #41's personal belongings daily and spoke to her like a three-year old.- An email dated 02/18/26 said an unclarified aide enacted verbal abuse by continually yelling at Resident #41.- An email dated 03/19/26 said a set of cabin socks were stolen from Resident #41.Record review of the ODH Certification and Licensure website revealed the only self-reported incident (SRI) involving Resident #41 within the last six months was SRI #271831 dated 03/09/26, which involved an allegation of neglect and mistreatment by LPN #533 and CNA #576.Interview with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) #563, and Regional Nurse #626 on 04/20/26 at 2:26 P.M. revealed they denied knowledge of all abuse, neglect, and misappropriation allegations in the above noted emails. They confirmed these allegations did not have SRI investigations or documented reporting to ODH.Record review of the resident concern log for the past year revealed no documented concerns regarding Resident #41.Record review of the facility's abuse policy dated 01/01/24 revealed all allegations of abuse, neglect, and exploitation were to be reported to the state agency within 2 hours if the allegations involved abuse and 24 hours if they did not.This deficiency represents noncompliance investigated under Master Complaint Number 2961312 and Complaint Numbers 2726820, 2623912 and 2606964.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the Ohio Department of Health (ODH) Certification and Licensure website, and facility policy review, the facility failed to thoroughly investigate all allegations of abuse, neglect, and misappropriation. This affected one (Resident #41) of two residents reviewed for abuse. The facility census was 42.Findings include: Record review of Resident #41 revealed she was admitted [DATE] with diagnoses including dementia, anxiety disorder, and chronic respiratory failure. Her Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had mild or no cognitive impairment. Review of her progress notes revealed no evidence of documented abuse or misappropriation allegations in 2026. She was hospitalized [DATE] for sepsis and returned to the facility 03/06/26.Record review of emails sent by the daughter of Resident #41 verified email addresses of facility staff and the ODH revealed the following allegations regarding the care of Resident #41:- An email dated 01/24/26 said Licensed Practical Nurse (LPN) #533 gave Tramadol (opioid pain medication) doses too close together and behaved with animosity and hatred, saying ?ridiculous things' about the resident and daughter.- An email dated 02/02/26 said LPN #533 intimidated Resident #41, who was afraid to be alone with her.- An email dated 02/05/26 said LPN #533 did not give medications as ordered and falsely said the resident refused care. Resident #41 also called for incontinence care and had her light turned off with no response for several hours.- An email dated 02/09/26 said Certified Nurse Aide (CNA) #576 disrespected Resident #41's personal belongings daily and spoke to her like a three-year old.- An email dated 02/18/26 said an unclarified aide enacted verbal abuse by continually yelling at Resident #41.- An email dated 03/19/26 said a set of cabin socks were stolen from Resident #41.Record review of the ODH Certification and Licensure website revealed the only self-reported incident (SRI) involving Resident #41 within the last six months was SRI #271831 dated 03/09/26, which involved an allegation of neglect and mistreatment by LPN #533 and CNA #576.Interview with Resident #41 on 04/19/26 at 10:08 A.M. revealed workers yelled at her quite often and aides were very nasty. She could not remember the specifics of who or what was involved with these events. She also said staff took the cord from her Bluetooth radio last week, rendering it unusable.Interview with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) #563, and Regional Nurse #626 on 04/20/26 at 2:26 P.M. revealed they denied knowledge of all abuse, neglect, and misappropriation allegations in the above noted emails and interview.Interview with the daughter of Resident #41 on 04/21/26 at 4:07 P.M. revealed she believed staff stole the SD card from a camera she had set up in Resident #41's room until the facility removed it, which contained footage of staff screaming at the resident.Record review of SRI #271831 dated 03/09/26 revealed staff were alleged to have spoken to the resident in a loud, abrasive manner. The report identified concerns of mistreatment with no specifics noted. There was no noted interview or attempted interview with the daughter, and the only noted interview with Resident #41 was the same questionnaire form other residents received wherein pre-written answers were circled indicating she felt safe and had no concerns with neglect or mistreatment. There was also no documented attempt to request footage from a monitoring camera, which was identified in progress notes to be in the resident's room until the facility removed it on 03/12/26.The surveyor confirmed the above findings in the SRI with Regional Nurse #626 on 04/22/26 at 2:34 P.M.Following the above interview, the facility furnished an email from the daughter of Resident #41 dated 03/07/26. In it, the daughter said the two alleged perpetrators were not allowed to go in Resident #41's room given what took place on February 18 and for the management to please be aware there is video documenting everything that went on in her room that day. She said Resident #41 told her she was terrified of the alleged perpetrators. She said she lost track of how many times she reported the alleged perpetrators via emails. She said that LPN #533 publicly called Resident #41 a pain in the [expletive] and was negligent in giving care and medications. She also said her concerns kept being swept under the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	carpet.Following the above interview, the facility furnished a call log allegedly demonstrating they made efforts to contact the daughter of Resident #41 for interview during the SRI investigation. The log showed one outbound call to the daughter's phone number labeled no answer, two labeled answered, and one documented inbound call from the daughter. There was no record of the results of these calls.Interview with the Administrator on 04/22/26 at 3:16 P.M. revealed he said Resident #41 did not know what he was talking about when he spoke with her for the SRI investigation. He said the resident's daughter never answers her phone and never calls back when he tries to reach out regarding any of her concerns.Record review of the resident concern log for the past year revealed no documented concerns regarding Resident #41.Record review of the facility's undated electronic monitoring policy revealed the facility would not independently access recordings but would request the recordings if needed for an abuse or other investigation.Record review of the facility's abuse policy dated 01/01/24 revealed the facility was to immediately investigate reports of abuse, neglect, or exploitation. This investigation was to include interviewing all involved persons and to be focused on determining if abuse occurred. All alleged violations were to be reported to the state agency within 2 hours if the allegations involved abuse and 24 hours if they did not.This deficiency represents noncompliance investigated under Master Complaint Number 2961312 and Complaint Numbers 2726820, 2623912 and 2606964.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interviews, and facility policy review, the facility failed to ensure that the Minimum Data Set (MDS) assessments accurately reflected Resident #18's clinical status. This affected one (Resident #18) of 22 residents sampled during the survey. The facility census was 42.Findings include:Review of the medical record for Resident #18 revealed she was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, dependence on respirator (ventilator status), and heart failure.Record review showed Resident #18 experienced substantial weight changes between October 2025 and April 2026, increasing from 398.9 lbs to 557.8 lbs. Despite this significant change, the MDS assessments dated 10/26/25, 01/21/26, and 04/08/26 all coded that the resident had no 5% weight gain in one month and no 10% gain in six months, and the same weight of 399 lbs was repeatedly entered for multiple assessments.During an interview on 04/22/26 at 11:43 A.M., the Registered Dietitian (RD #630) confirmed that she was aware the resident had gained over 100 lbs but stated she had no current weight available at the time of the January 2026 assessment and therefore reused a previous weight, despite the resident's significant documented weight increase. The RD verified that she had not assessed the resident in person and relied only on risk meetings and the electronic medical record (EMR) to complete nutritional documentation. She acknowledged that the information in the medical record did not accurately reflect Resident #18's current nutritional status and confirmed the MDS coding was not accurate based on available clinical information.Review of the facility's MDS 3.0 Completion policy (revised 12/01/25) showed staff are required to attest to the accuracy of the sections they complete. The facility did not implement this policy as evidenced by the repeated use of outdated weight data and inaccurate MDS coding.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to provide appropriate oral and nail care for dependent residents. This affected one (Resident #28) of three residents reviewed for activities of daily living (ADL). The facility census was 42.Findings include:Record review of Resident #28 revealed he was admitted to the facility 07/03/25 with diagnoses including respiratory failure, paraplegia, and anoxic brain damage. His care plans dated 07/21/25 noted he was totally dependent on staff for ADL, and his nails should be checked daily for length and cleanliness. His Minimum Data Set (MDS) 3.0 assessment dated [DATE] identified he was never or rarely understood, was dependent on staff for ADL care, and his mouth could not be assessed for dental problems. He was ordered to receive oral care twice per day and had no orders indicating any treatment of thrush (an oral fungal infection commonly involving white patches on the tongue).Observation of Resident #28 on 04/21/26 at 11:10 A.M. revealed his teeth appeared brown, although the surveyor could not determine if the color was natural or due to debris in the mouth. He was not interviewable or responsive to questions. His mouth hung open, and a white rough layer could be visualized on the tongue consistent with thrush. His fingernails extended roughly one to two centimeters from the top of the fingers and curled downwards at their ends.Interview with Assistant Director of Nursing (ADON) #563 on 04/21/26 at 11:31 A.M. verified these findings.This deficiency represents noncompliance investigated under Master Complaint Number 2961312, and Complaint Numbers 2726820 and 2668853.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, resident interviews, staff interviews and facility policy review, the facility failed to ensure resident activity preferences were honored. This affected two (Residents #1 and #26) of two residents reviewed for activities. The facility census was 42.Findings include:1. Review of the medical record for Resident #1 revealed he was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, necrotizing fasciitis and type II diabetes mellitus.Review of the care plan dated 12/31/25 revealed Resident #1 required encouragement to participate in activities of interest, was dependent on staff for activities with interventions including in-room activities if unable to attend out-of-room activities, allow to plan own leisure time activities, and respect choices in regard to limited activities. Review of the activities assessment dated [DATE] revealed Resident #1 preferred independent leisure activities, including but not limited to, a tablet and/or phone.Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated he was alert and oriented to person, place, and time. Resident #1 was dependent on staff for activities of daily living (ADL).Interview and observation on 04/19/26 at 10:38 A.M. revealed Resident #1 lying in bed. Resident #1 revealed he was upset due to not being able to watch the National Basketball Association (NBA) Playoffs because certain television channels did not work. Resident #1 revealed he preferred to stay in bed and watch television or use his personal cellphone and/or tablet. Resident #1 revealed he reported his television issues to the facility staff including the maintenance department. Observation and return demonstration by Resident #1, revealed channels 14, 15, 18, and 21, did not work.Review of the completed and closed maintenance work orders dated 03/20/26 through 04/20/26 revealed Resident #1 television channels (14, 18, 21) were not working. Review of the work orders revealed no entry for television channel 15.Interview and observation on 04/21/26 at 10:37 A.M. with Maintenance Director (MD) #590 entered Resident #1's room in regard to the television channels. MD #590 revealed he fixed Resident #1's channels, and there were no present no issues. Resident #1 yelled out No, you didn't. Return demonstration by Resident #1 revealed the television channels were not fixed and were inoperable. MD #590 revealed he had previously reset the system and there was nothing he could do about fixing Resident #1 channels. MD #590 revealed he would have to call the outsourced cable provider to have them visit the facility to fix the issue. MD #590 revealed resident's concerns related to maintenance department were entered into electronic monitoring system and once received, he addressed the issue and closed the work order once completed. MD #590 confirmed and verified Resident #1's work order was submitted, not completed, but closed out as rectified.Follow-up interview on 04/21/26 at 11:13 A.M. with MD #590 revealed Resident #1's television was now fixed after surveyor intervention, after closing the work order as completed, and not requiring contact with the outsourced cable provider. MD #590 verified the above findings at the time of the interview.Review of the facility document titled Safe and Homelike Environment, revised 06/01/24, revealed the facility had a policy in place that any furniture in disrepair would be reported to the maintenance department promptly and resolved. Review of the facility document titled Activities, revised 06/01/24, revealed the facility had a policy in place that ongoing support of resident's choice of activities, including in-room activities, according to their personal preferences would be honored. 2. Review of the medical record for Resident #26 revealed he was admitted to the facility on [DATE] with diagnoses including quadriplegia (C1-C4 complete), osteomyelitis, and injury at C4 level of cervical spinal cord.Review of the recreation assessment dated [DATE] revealed going outside to get fresh air was very important to Resident #26.Review of the MDS 3.0 assessment dated [DATE] revealed Resident #26 had a BIMS score of 15 that indicated he was alert and oriented to person, place, and time. Resident #26 had impairment on both sides upper and lower extremities and was dependent on staff for ADL.Review of the care plan dated 04/29/26 revealed Resident #26 required (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encouragement to participate in activities of interest, was dependent on staff for activities with interventions including in-room activities if unable to attend out-of-room activities, allow to plan own leisure time activities, arrange for activity aide to visit and designate activity, escort to activities of choice that reflect prior interests, and respect choices in regard to limited activities.Interview on 04/19/26 at 2:21 P.M. with Licensed Practical Nurse (LPN) #563 revealed Resident #26 was noncompliant with outside visits due to violating the smoking policy. Resident #26 was witnessed smoking marijuana outside in the facility parking lot and was now not allowed to go outside without supervision, and Resident #26's Guardian was in agreement. She was unable to identify the last time Resident #26 was taken outside.Interview and observation on 04/19/26 at 2:52 P.M. with Resident #26 revealed he was lying in bed. He stated facility staff informed him he could not go outside. Resident #26 stated I can't do much. I can't walk. I can't do anything for myself. I just want to go outside sometimes. The only thing I can really do is be on my phone. He did not recall the last time he went outside.Interview on 04/22/26 at 1:36 P.M. with Resident #26's Guardian revealed Resident #26 was unable to walk and was completely dependent on staff due to paralysis and quadriplegia. Resident #26 loved to go outside and sit due to being very young, residing in the facility and not having much in common with the facility population. Resident #26 was not allowed to go outside with staff supervision due to a previous incident regarding not following the facility's smoking policy. Resident #26 had not been taken outside by staff, and she was informed by the facility that it was a law that he could not go outside. Resident #26 had not been taken outside.Review of Resident #26's social programs participation log in the last 30 days revealed no participation in patio and/or deck socialization.Review of the participation record for the month of April 2026, provided by Activity Director (AD) #545 revealed Resident #26 was taken to the patio one time.Review of the activities calendars for March and April of 2026 revealed one possible outside activity listed, gardening, on 04/22/26. Reviews of the calendars revealed no designated activities for outside or patio leisure activities.Interview on 04/22/26 at 1:54 P.M. with AD #545 revealed Resident #26 liked to go outside as an activity preference. Resident #26 typically stayed to himself, utilized his phone, listened to music, and only participated in one other activity, which consisted of food activities. She only went outside depending on the weather and the number of residents wanting to participate. Resident #26 went outside once the week prior, 04/12/26 - 04/18/26 and could not recall any other times. AD #545 verified the above findings during the interview.Review of the facility document titled Activities, revised 06/01/24, revealed the facility had a policy in place that ongoing support of resident's choice of activities, including in-room activities, according to their personal preferences would be honored.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure that a resident with a documented Stage IV (full thickness tissue loss with exposed bone, tendon or muscle) pressure injury received repositioning according to their plan of care and accepted standards of practice. This affected one (Resident #28) of three residents reviewed for pressure sore care. The total census was 42.Findings include:Record review of Resident #28 revealed he was admitted to the facility 07/03/25 with diagnoses including respiratory failure, paraplegia, and anoxic brain damage. His care plans dated 07/21/25 noted he was totally dependent on staff for activities of daily living (ADL) and that he was at risk for skin breakdown and should be turned every two hours. His Minimum Data Set (MDS) 3.0 assessment dated [DATE] identified he was never or rarely understood, was dependent on staff for bed mobility, and had pressure sores present on admission. Review of his most recent wound assessment dated [DATE] revealed he had a Stage IV pressure sore on his buttocks.Observation and attempted interview of Resident #28 on 04/20/26 at 10:18 A.M. revealed he was not interviewable and demonstrated no evidence of understanding or awareness of the surveyor's questions. He was in bed laying on his back with a wedge cushion on a bedside table at the foot of the bed. His head was elevated roughly 30 degrees and there were no pillows or other devices beneath either side to turn him off his back.Observations of Resident #28 on 04/20/26 at 12:54 P.M., 3:09 P.M., and 5:05 P.M. revealed he continued to be on his back with the wedge pillow on a bedside table during each observation.Interview with Assistant Director of Nursing (ADON) #563 on 04/20/26 at 5:15 P.M. confirmed Resident #28 had not been repositioned for several hours that day.This deficiency represents noncompliance investigated under Complaint Number 2726820.

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	365825	A. Building B. Wing	04/29/2026

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Grande Oaks	24579 Broadway Ave Oakwood Village, OH 44146

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview and facility policy review, the facility failed to implement therapy ordered contracture care for one (Resident #7) of one resident reviewed for range of motion and mobility. The facility census was 42.Findings include:Review of the medical record revealed Resident #7 was admitted on [DATE] with diagnoses that included Moyamoya Disease (a progressive disorder of blocked arteries at the base of the brain), severe protein calorie malnutrition, anemia, acute kidney failure, metabolic encephalopathy (brain dysfunction), dysphagia (difficulty swallowing), cerebral infarct (tissue death), and hypertension (high blood pressure). She was admitted under hospice services on 08/20/25. The Brief Interview for Mental Status (BIMS) assessment dated [DATE], revealed a score of 0 (severe impairment), and the (Minimum Data Set) MDS 3.0 Quarterly assessment dated [DATE] and the MDS 3.0 Quarterly assessment dated [DATE], revealed the resident was dependent on staff for all activities of daily living (ADL) and mobility. Review of the resident care plan initiated on 01/29/25 and revised on 08/25/25, revealed a care plan for assistance needed for ADL related to cognitive impairment, immobility, pain, and weakness. No interventions related to hand/wrist contractures present upon admission were evident in the care plan.Review of the revised care plan (readmission date of 08/19/25) initiated on 09/04/25 revealed a care plan for assistance needed for ADL related to cognitive impairment, decreased mobility, and decreased physical functioning. Interventions included checking nails daily for length and cleanliness, trimming, and cleaning as necessary.Review of the Therapy Communication Form dated 04/10/25 by the Director of Therapy (DOT) #627, revealed communication/instruction to perform hand hygiene, gentle passive range of motion (PROM), apply palm guards, remove for hygiene, monitor skin for any signs or symptoms of discomfort and notify therapy, and provide nail care as needed.Review of the Prescribers Telephone Order dated 04/14/25 and authored by Occupational Therapist (OT) #631, revealed an order for Pt. to be encouraged to wear bilateral palm guards for up to 8 hrs. daily with appropriate skin checks. The telephone order revealed blank spaces for the signature of the prescriber, physician's/prescriber's order sheet, nurses' notes, patient care plan, medication/treatment sheet, dietary, and family notified.Review of the OT notes by DOT #627 dated 06/16/25 through 07/23/25 revealed two new palm protectors were provided when the resident returned from a hospital stay with continued therapy of bilateral upper extremity PROM to improve range of motion as tolerated. Further, the OT notes on 07/02/25 and 07/15/25 revealed staff training for hand hygiene and PROM prior to placing the palm guards. On 07/21/25, the therapy notes revealed to continue with staff education to don/doff (put on and take off) palm protectors following discharge from OT services. On 07/23/25, the OT notes indicated to educate nursing staff to remove the palm guard at least daily for hand hygiene.Review of the Therapy D/C Recommendation Sheet (July 2025), revealed Resident #7 was to wear bilateral palm guards for at least eight hours with appropriate skin checks. The exercise program consisted of two sets of 10 repetitions PROM to bilateral upper extremities, and to provide hand hygiene daily to reduce risk of skin breakdown. Five nursing personnel on 07/07/25, 07/15/25, and 07/19/25 were in-serviced and documented on the sheet.Review of the medical record Treatment Administration Record (TAR) April 2025 through April 2026, and the Facility Order Listing Report, 04/01/25 through 04/30/26 for Resident #7, revealed no treatment order for palm guards.Observation on 04/19/26 at 12:02 P.M. and 1:00 P.M. revealed Resident #7 with bilateral hands with no palm guard or barrier between the fingers and the palm of the hand, such as a pad or washcloth.Observation on 04/20/26 at 7:00 A.M. and 2:00 P.M. and on 04/21/26 at 7:30 A.M., revealed no palm guards or palm barriers to contracted bilateral hands and wrists, with long nails pressing against the palm.Interview on 04/21/26 at 10:30 A.M. with Certified Nurse Aide (CNA) #510, revealed Resident #7 does not have anything for her hand contractures and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that they wouldn't be able to put anything in her hands because she was so contracted. Interview on 04/21/26 at 4:15 P.M. with the Regional Director of Clinical (RDC) #626 verified that Resident #7 had no palm guards or palm barriers to bilateral hands. RDC #626 verified the resident's nails on both hands were long and pressing against the skin of the palms.Observation on 04/22/26 at 7:20 A.M. revealed Resident #7's nails were trimmed and no longer pressing against the palm of the hands. Resident #7 had no palm guards or palm barriers to bilateral hands.Interview on 04/22/26 at 8:00 A.M. with CNA #622 revealed she was able to access the Kardex report for Resident #7 on the computer. CNA #622 revealed the care plan for Resident #7 included the interventions of air mattress, float heels as tolerated, every two-hour positioning, inspect skin, pressure reducing cushion to chair, pressure reducing mattress, preventative skin care, check nails daily for length and cleanliness.Interview on 04/22/26 at 9:45 A.M. with the Director of Nursing (DON) and RDC #626 verified there was no care plan regarding contractures for Resident #7, care plan intervention, or treatment for the therapy recommendations on 04/14/25 and the therapy discharge recommendation sheet in July 2025. Further, the DON and RDC #626 verified the therapy orders for palm protectors dated 04/14/25, and no orders were in place. The DON revealed the facility does not have a formal restorative nursing program.Interview on 04/22/26 at 2:00 P.M. with the DOT #627, verified the therapy recommendations for palm protectors dated 04/14/25 were not ordered and verified the Therapy D/C Recommendation Sheet (July 2025) recommendations.Observation on 04/27/26 at 10:10 A.M. and on 04/28/26 at 2:40 P.M., revealed Resident #7 had no palm guards or palm barriers in place.Interview on 04/28/26 at 2:49 P.M. with DOT #627, revealed that the Resident Assessment Coordinator sent out a list of residents requiring therapy screens monthly, and hospice residents were not normally picked up by therapy due to the hospice plan of care and hospice approval process. DOT #627 revealed her goal was to work with hospice to evaluate Resident #7 for a final recommendation regarding the hand contractures, to consider the risk versus the benefit of appliance application.Review of the facility policy titled, Prevention of Decline in Range of Motion (revised 10/01/22), revealed the facility will provide treatment and care which included appropriate equipment (braces or splints), and specialized rehabilitation, restorative, or maintenance, and assistance as needed. Further, the care plan interventions would be developed and delivered through the facility's restorative program or through specialized rehabilitative services as ordered by the attending practitioner.Review of the facility policy titled, Resident Care (revised 10/01/22), revealed personal hygiene for a resident includes the cleaning and cutting of fingernails and toenails (diabetic nail care completed by a nurse).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident and staff interviews, and policy review, the facility failed to provide adequate supervision and failed to ensure the safe use of assistive devices during care and transfers. This failure resulted in one resident (#18) falling from bed during singleˆstaff incontinent care despite weighing 557.8 pounds and being dependent for activities of daily living (ADL), and one resident (#32) sliding from a mechanical lift pad during transfer due to improper pad placement. This deficient practice affected two residents (#18 and #32) of three sampled residents reviewed for accidents. The facility census was 42.Findings include: 1. Review of the medical record for Resident #18 revealed she initially admitted on [DATE] and readmitted on [DATE]. Diagnoses included chronic respiratory failure, dependence on respirator and heart failure. Review of the care plan dated 04/15/22 revealed Resident #18 required assistance for activities of daily living (ADL), was at risk for falls, had high body mass index (BMI) related to obesity, and had potential for alteration in skin integrity with interventions including: protective and preventative care, inspect for any reddened areas during daily care, observe, monitor and report changes, observe changes in ADL ability, and adjusting assistance as needed with a goal to be free from injury. Review of the care plan revealed no actual areas of skin impairment related to the right leg were present. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #18 was cognitively intact, dependent on staff for bed mobility and bathing, had limited range of motion to both lower extremities, and was always incontinent of bowel and bladder. Review of the weight records for the prior 90 days showed the resident weighed 557.8 pounds. Review of the progress notes revealed on 02/04/26 at approximately 5:15 A.M., Resident #18 fell from bed during incontinent care being performed by one certified nursing assistant (CNA). The resident rolled and fell to the floor while the CNA attempted to assist her. There was no visible injuries initially; however, by 12:04 P.M., the resident reported pain to the right leg. Portable xˆrays could not be completed due to pain, and she was transferred to the hospital. Hospital evaluation identified significant rightˆleg pain but no fracture. Review of the fall investigation dated 02/04/26 at 5:23 A.M. revealed LPN #543 was notified by CNA #606 that Resident #18 was turning during ADL care and fell on the floor. LPN #543 noted Resident #18 was lying in a supine position on the floor, alert, conscious, and talking. Resident #18 was assessed immediately and was able to move all limbs at baseline with no evidence of pain or discomfort noted. Review of the investigation revealed the fire squad was called for assistance to get Resident #18 back into bed. Resident #18 refused to go to the hospital for further evaluation due to reports of no pain or discomfort. Resident #18 was sent to the hospital to have an evaluation after her refusal with all hospital x-rays negative. Review of the witness statement, within the fall investigation, dated 02/04/26 written by CNA #606 revealed she was providing care to Resident #18, and she proceeded to roll over onto her side towards the door. Resident #18 then grabbed the rail and was trying to get her leg on top of the other leg and in the process, she kept rolling and fell onto the floor. CNA #606 revealed she ran to the other side where she was to check on her before running out of the room for assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital paperwork dated 02/04/26 at 2:09 P.M. for Resident #18 arrival to the Emergency Department (ED) revealed she arrived via the fire department due to a fall with a pain level of 10 out of 10 to both legs. Resident #18 revealed she had pain just below her knee to the ankle after receiving care for a fall at the facility. Resident #18 physical exam revealed right lower extremity had tenderness of the anterior leg to the ankle and after x-rays, no fractures were found. Resident #18 was subsequently discharged back to the facility with a contusion of the right lower extremity after sustaining a fall. During an interview on 04/19/26 at 10:25 A.M., Resident #18 stated she had fallen out of bed during care. One staff member was providing care when she was pushed out of bed, fell on the floor and injured her leg. Resident #18 said the wound was not healing, and she was now at risk of losing her leg. During interviews on 04/20/26, Regional Nurse #626 and LPN #563 acknowledged Resident #18 required a twoˆperson assist for transfers using a mechanical lift and weighed 558 pounds. Nevertheless, they failed to recognize that these same factors necessitated twoˆstaff assistance for bed mobility and incontinent care and continued to assert that she required only one staff member for ADL, despite the MDS documenting she was dependent on at least two staff for ADL. A reasonable person, considering Resident #18's 557.8ˆpound weight, complete dependence for bed mobility, bilateral lowerˆextremity limitations, incontinence, and documented requirement of twoˆstaff assistance for transfers, would expect that at least two staff members were necessary to safely perform bed mobility and incontinent care. The facility's failure to provide twoˆstaff assistance constituted inadequate supervision and resulted in a foreseeable and avoidable fall with subsequent injury. 2. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including hemiplegia (partial paralysis) and hemiparesis (partial muscle weakness) following a cerebral infarction (stroke), hypertension (high blood pressure), dysphagia (difficulty swallowing), dysarthria (difficulty speaking), acute and chronic respiratory failure, heart failure, and type II diabetes mellitus. Review of the care plan created on 08/09/22 revealed Resident #32 had a potential risk for falls with interventions including therapy to screen/evaluate when indicated, observe for changes in ADL ability and adjust assistance provided accordingly, ensure the call light is within reach, assist with transfers as needed, high-low bed to be in lowest position while occupied, keep bed against wall (added 09/20/22), educating the resident to use the call light for assistance (added 07/30/23), perimeter mattress to bed (added 01/10/24) remind her to ask for help to obtain items off the floor (added 01/08/26). Review of the care plan created on 08/10/22 revealed Resident #32 required assistance with ADL related to status post craniotomy, encephalopathy, respiratory failure, obstructive hydrocephalus, and dysphagia. Interventions including keeping call light within reach, providing incontinence care with routine rounds and as needed, and chair to bed/bed to chair transfers via mechanical lift (added 02/06/24). The MDS dated [DATE] documented the resident was cognitively intact and dependent on staff for ADLs including toilet hygiene, bathing, lowerˆbody dressing, footwear, and transfers. The Fall Risk Assessment (02/05/26) classified her as a moderate fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note (04/04/26) documented that on 04/03/26, during a twoˆstaff transfer from wheelchair to bed using a mechanical lift, the resident slid from the lift pad to the floor because the pad was improperly positioned. Review of the facility document titled, Fall/Skin Incident Report (04/03/26), CNA #506 revealed while attempting to transfer the resident to the bed, they noticed the mechanical lift pad was not all the way under the resident's buttocks and tried to adjust her the best we could. It wasn't good enough because she slipped out of it. Review of LPN #618's written statement revealed when the resident was being transferred, she slid from the mechanical lift pad onto the floor. The facility's Fall Prevention and Management Policy (revised 10/02/22) requires that all residents be assessed for fall risks on admission, quarterly, after any fall, and as needed. Identified risks must lead to individualized interventions, added to the care plan, monitored for effectiveness, and revised as needed. All falls must be assessed by nursing, investigated, and reviewed by the interdisciplinary team, and appropriate fallˆprevention measures must be implemented. Per policy, a fall includes any unintentional descent to the floor, including near misses, and the facility must ensure safe supervision and correct use of assistive devices to prevent foreseeable accidents. This deficiency represents non-compliance investigated under Complaint Number 2795717.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interviews, and facility policy review, the facility failed to ensure Resident #18's care was adequately supervised by a physician. Specifically, the facility failed to obtain, initiate, and implement physician orders for weight monitoring despite significant, documented changes in nutritional status and body weight. The facility also failed to notify the physician of significant weight gain requiring clinical intervention. This deficient practice resulted in Resident #18 experiencing an undocumented and unmonitored weight increase of approximately 159 pounds over a fiveˆmonth period, with no corresponding physician notifications, no new orders, and no comprehensive assessment or monitoring as required. This affected one (Resident (#18) of four reviewed for nutrition. The facility census was 42.Findings include:Review of the medical record for Resident #18 revealed she was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, dependence on respirator (ventilator status), and heart failure.Review of the care plan dated 04/15/22 revealed Resident #18 required assistance for ADL, was at risk for falls, and had a high body mass index (BMI) related to obesity, with interventions including observing, monitoring and reporting changes, assisting with activities of daily living (ADL), following physician orders and monitoring weights.Review of the medical record revealed Resident #18's weight increased from 398.9 pounds (lbs) on 10/23/25 to 557.8 lbs on 04/02/26, an unplanned gain of 159 lbs. Despite the significant change, there was no documentation of physician notification or orders for daily, weekly, or monthly weights as required.Nutrition assessments dated 10/31/25 and 01/23/26 were identical with no updated recommendations, despite the resident's ongoing nutritional risks. Assessments continued to reference outdated information and did not reflect the resident's significant increases in weight.A progress note dated 02/20/26 documented that Resident #18 had a weight of 573 lbs following hospitalization, yet no physician notification or followˆup orders were documented.Although a nutrition review dated 04/10/26 indicated the resident's BMI was 90 and her weight gain required confirmation with daily weights, there were no corresponding physician orders, documentation of attempts to obtain orders, or weight monitoring followˆthrough.Interviews with Certified Nursing Assistant (CNA) #570 on 04/21/26 at 12:19 P.M. and Licensed Practical Nurse (LPN) #513 on 04/21/26 at 12:21 P.M. confirmed that Resident #18 was not on a list for weight monitoring and had no orders for daily, weekly, or monthly weights. Staff were unable to identify when the resident was last weighed.Interview on 04/22/26 at 11:43 A.M. with Registered Dietitian (RD) #630 confirmed that although she was aware the resident gained more than 100 lbs, she was not aware of any weightˆmonitoring orders and verified no physician orders were present in the medical record.Review of the facility document titled Weight Monitoring revised 12/01/22, revealed the facility had a policy in place to ensure all residents maintain acceptable parameters of nutritional status, including body weight, identify, implement, monitor and modify interventions, and to inform the physician of significant changes in weight to order and put in place nutritional interventions and documented in the resident's medical record. Review of the document revealed the facility did not implement the policy. Review of the facility document titled Physician Orders dated 10/01/22, revealed physician, nurse practitioner and physician assistant orders may be received by telephone by a licensed nurse or other licensed or registered health care specialist who are authorized to legally to do so. Review of the document revealed the facility did not implement the policy.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure pharmacy recommendations were addressed in a timely manner. This affected one (Resident #2) of five residents reviewed for unnecessary medications. The facility census was 42.Findings include:Review of the medical records for Resident #2 revealed an admission date of 10/02/24. Diagnoses included pain, type II diabetes mellitus with diabetic neuropathy, anemia, depression, post-traumatic stress disorder (PTSD), and anxiety disorder.Review of the pharmacy recommendation dated 05/05/25 regarding Diazepam (antianxiety) 2.5 milligrams (mg) twice daily (BID) for a gradual dose reduction (GDR) trial and Duloxetine (antidepressant) 30 mg daily, Sertraline (antidepressant) 100 mg daily, and Trazadone (antidepressant) 100 mg at bedtime (QHS) GDR trial.Review of the pharmacy recommendation dated 07/14/25 regarding Diazepam 2.5 mg BID. The pharmacy recommendation also noted it is time to consider a GDR trial. Please check one of the following. Nothing was noted on the recommendation. Review of the nursing note dated 09/16/25 at 1:11 P.M. revealed pharmacy recommendation reviewed by physician with the decline for GDR trail for Diazepam 2.5 mg, Duloxetine 30 mg, Sertraline 100 mg, and Trazodone 100 mg due to multi contraindications. Resident #2 made aware with no concerns at this time.Review of the pharmacy recommendation dated 11/03/25 revealed the resident is receiving Tylenol/Acetaminophen (analgesic) 1,000 mg three times a day (TID). She also has two other as needed (PRN) orders, one for oral use, one for rectal use. I wanted to ask to discontinue (d/c) the PRN orders since she was already at the maximum recommended daily dosage of three grams with the routine order. Handwritten on the pharmacy recommendation was dc'd 1 prn, decreased routine to 500 mg dated 04/09/26.Review of the pharmacy recommendation dated 03/02/26 revealed 1) The resident (Resident #2) is receiving Tylenol/Acetaminophen 1,000 mg TID. She also has two other PRN orders, one for oral use, one for rectal use. I wanted to ask to d/c the PRN orders since she is already at the maximum recommended daily dosage of 3 grams with the routine order. Handwritten in green next to this was addressed 04/09/26. Nursing entered this resident's Duloxetine for the sprinkle caps, which is only available as brand name Drizalma (costing over $7 per dose). This dosage form is reserved medication via tube. May I please ask you to clarify if this order was to be for the generic Cymbalta (Duloxetine particle capsules, Not sprinkle caps)? *Nursing, once clarified, please d/c and re-enter this order for the correct formulation. Suggest typing in Cymbalta and all equivalent formulations will populate as you type. Handwritten in green was addressed 04/03/26.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 had intact cognition, had no behaviors, and received antianxiety, antidepressant, antibiotic, diuretic, opioid, antiplatelet, hypoglycemic, and anticonvulsant. Review of the nursing note dated 04/02/26 at 7:19 P.M. revealed new orders received to discontinue PRN Acetaminophen (Tylenol) as the resident is currently receiving a scheduled dose. Order also received to discontinue Duloxetine 30 mg sprinkle capsule and initiate Duloxetine particles 30 mg by mouth (PO) daily. All orders noted and will be implemented as prescribed.Review of the nursing note dated 04/09/26 at 4:31 P.M. revealed notified physician of pharmacy recommendation of max dose of Tylenol, physician gave new order to d/c Tylenol suppository and reduced Tylenol 500 mg 2 tabs to 1-tab TID. Resident #2 made aware of new order.Interviews on 04/22/26 at 2:47 P.M. and 4:17 P.M. with Regional Registered Nurse (RRN) #626 verified the pharmacy recommendations were not addressed timely. RRN #626 verified the policy did not indicate a timeframe for addressing the pharmacy recommendations.Review of the facility policy Medication Regimen Review, revised 09/30/22, revealed the facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. The policy did not indicate a timeframe of when the pharmacy recommendation should be addressed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on record review, observation, review of the facility policy and interview, the facility failed to ensure the correct serving size for the mechanically altered meat was served. This affected three (Residents #6, #22, and #33) of three residents that received a mechanically altered diet. The facility census was 42.Findings include:Observation of the tray line on 04/21/26 between 12:31 P.M. and 12:49 P.M. revealed Dietary Aide (DA) #555 serving mechanically altered meals using a green-handled #12 scoop, providing only one scoop of mechanically altered meat per meal. At 12:49 P.M., staff were observed pushing the last meal cart to the final unit.Review of the diet extension sheet showed that the mechanically altered meat (beef stroganoff) was to be served using a #6 scoop.During an interview on 04/21/26 at 12:50 P.M., DA #555 and Regional Dietary Manager (RDM) #900 confirmed that the green-handled scoop used was a #12 scoop. RDM #900 stated that, when using a #12 scoop, DA #555 should have provided two scoops to meet the required portion size. DA #555 verified she had provided only one scoop to each resident receiving mechanically altered beefReview of the diet order listing report dated 04/19/26 confirmed that three residents (Residents #6, #22, and #33) were receiving mechanically altered diets.Review of the facility's undated Scoop Sizes chart showed that a #12 green scoop provides 2.78 ounces, while the #6 white scoop provides 4.66 ouncesReview of the Portion Control/Spreadsheets policy (revised 08/01/24) indicated that to ensure nutritional adequacy, residents must receive the appropriate portions of food as planned on the menu.This deficiency represents non-compliance investigated under Complaint Numbers 2726820,2623912, and 1320283 (OH00166923).

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	365825	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Oaks	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review and staff interviews, the facility failed to ensure the accuracy and consistency of the medical record when resident documentation contained conflicting information, including two different mattress orders that were both documented as being in place for the same dates. This affected one (Residents #17) of 22 residents sampled during the survey. The facility census was 42.Findings include:Review of Resident #17's medical record revealed an admission date 12/19/25 with diagnoses of bilateral primary osteoarthritis of hip, morbid obesity, and type II diabetes mellitus with hyperglycemia.Record review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 was cognitively intact and was at risk for developing pressure ulcers.During an interview on 04/19/26 at 10:12 A.M., Resident #17 reported he had not had an air mattress since the end of March 2026. However, physician orders dated 04/16/26 and the April 2026 Treatment Administration Record (TAR) showed the resident had active orders for both an air mattress and a pressureˆredistribution mattress from 04/16/26 through 04/19/26, and documentation reflected that both surfaces were in place from 04/16/26 through 04/18/26.An observation on 04/19/26 at 11:30 A.M. revealed Resident #17 was on a regular pressureˆredistributing mattress, not an air mattress. At the time of the observation, licensed Practical Nurse (LPN) #552 confirmed that only a pressureˆredistributing mattress was in use, despite the presence of two conflicting mattress orders in the record. The air mattress order was discontinued following this observation and interview.This deficiency represents noncompliance investigated under Complaint Number 2606964.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, resident interview, staff interviews, review of the hospice contract and facility policy review, the facility failed to ensure requests for hospice services were honored for Resident #18 and failed to ensure a hospice care plans were updated for Resident #7. This affected two (Residents #7 and #18) of two residents reviewed for hospice services. The facility census was 42.Findings include:1. Review of the medical record for Resident #18 revealed she was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, dependence on respirator (ventilator status), and heart failure. Review of the care plan dated [DATE] revealed Resident #18 required assistance for activities of daily living (ADL), was at risk for falls, and had a high body mass index (BMI) related to obesity, with interventions that included observing, monitoring and reporting changes, assisting with ADL, following physician orders and monitoring weights. Review of the care plan revealed Resident #18 had an advance directive of Do Not Resuscitate-Comfort Care Arrest (DNR-CCA), and no Cardiopulmonary Resuscitation (CPR) measures would not be attempted during cardiac arrest. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she was alert and oriented to person, place, and time. Resident #18 was dependent on staff for ADL. Review of the interdisciplinary care plan conference summary dated [DATE] revealed Resident #18 requested a palliative consultation through Echo Hospice. Interview on [DATE] at 10:25 A.M. with Resident #18 revealed she requested to be placed on palliative care through Echo Hospice, and it had been over a week, and she had not received any follow-up information. Interview on [DATE] at 3:21 P.M. with the Administrator revealed the facility honored all requests for hospice and palliative care services. The Administrator revealed the facility currently contracted with [NAME] Care and Western Reserve Hospice and any time a resident and/or family requested it, the process was started immediately. The Administrator revealed Social Services Designee (SSD) #574 started the process in-house. The Administrator revealed no one currently receives the services through Echo Hospice. Interview on [DATE] at 3:27 P.M. with SSD #574 revealed she was aware of Resident #18 palliative care consultation request with Echo Hospice. SSD #574 revealed Echo Hospice was called on the 13th or 14th of April, but no other follow-up was initiated. Interview on [DATE] at 3:45 P.M. with the Administrator and Regional Nurse #626 revealed palliative care consultations required physician orders. Regional Nurse #626 verified Resident #18 did not have an order for palliative care consultation in place and no further follow-up was initiated or documented in Resident #18's medical record. Review of the physician orders for Resident #18 revealed an order dated [DATE] for palliative care consultation, after surveyor intervention. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #7 was originally admitted to the facility on [DATE] and admitted to hospice services on [DATE] with diagnoses including Moyamoya Disease (blocked arteries at the base of the brain), severe protein calorie malnutrition, anemia, acute kidney failure, metabolic encephalopathy (damage to the brain), dysphagia (difficulty swallowing), cerebral infarct, and hypertension (high blood pressure). Review of the facility care plans revealed a care plan for hospice care election (initiated on [DATE]), with an intervention to coordinate the plan of care with the resident, family, and hospice. Review of the initial Hospice care plan in the physical chart dated [DATE] revealed an active plan of care for continuity of care due to ongoing care needs and safety due to the effects of medication or treatment. There were no updated Hospice plans of care in the electronic medical record or the physical chart until after surveyor intervention. Review of the MDS 3.0 Quarterly assessment dated [DATE] and the MDS 3.0 Quarterly assessment dated [DATE], revealed Resident #7 was dependent for all ADL and mobility. Review of the BIMS on [DATE], revealed Resident #7 had severe cognitive impairment, and a Fall Risk assessment on [DATE], revealed Resident #7 was at moderate risk for falls. Interview on [DATE] at 9:04 A.M. with the hospice Registered Nurse (RN) #628, revealed the facility notifies the hospice team with resident changes. Care conferences are held every two weeks (a hospice team conference), and the family is updated after each hospice visit. The hospice nurse does not attend or participate in the facility care conferences. RN #628 revealed the hospice plan of care is updated every 60 days during the recertification period and an updated hospice plan of care is delivered to the facility. Interview on [DATE] at 9:25 A.M. with the Director of Nursing (DON) revealed there is a hospice binder on the nursing units that contained the hospice plan of care for various residents. The DON confirmed there was no updated hospice plan of care on the unit for Resident #7. Interview on [DATE] at 10:00 A.M. with the DON and the Regional Director of Clinical (RDC) #626 verified the current hospice plan of care was not on the nursing unit or in the medical record for Resident #7. The hospice documents, Hospice Physician Recertification of Terminal Illness dated [DATE], and a Plan of Care Report dated [DATE], and updated Hospice care plans were placed in a binder titled, Reserve Care Hospice Binder and uploaded to the electronic medical record under the miscellaneous tab on [DATE] at 5:18 P.M. by the DON after surveyor intervention. The updated Hospice plan of care dated [DATE] included care plans for continuity of care due to ongoing needs, safety due to effects of medication or treatment, skin integrity due to disease progression, and urinary elimination due to disease progression. Review of the Hospice Care Plan Report prints on [DATE] at 5:30 P.M., effective [DATE] – present, revealed a care plan titled, Clinical Module Care Plan Problem with interventions to assess spiritual needs and visitation, build a relationship of trust and support, provide presence and support, and read/pray with the patient. No disciplines were identified for the interventions. Review of the Hospice Care Plan Report printed on [DATE] at 5:30 P.M., effective [DATE] – (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	present, revealed a care plan titled, EVV Care Plan with no interventions, and a Default Care Plan with no interventions assigned to the hospice nursing assistant. Further, a Clinical Module Care Plan Problem with interventions to assess spiritual needs and visitation, build a relationship of trust and support, provide presence and support, and read/pray with the patient. No disciplines were identified for the interventions. Review of the Hospice of Western Reserve contract effective [DATE], revealed the written plan of care is established, maintained, reviewed, modified by the transdisciplinary group (TDG), and reflect the participation of the Hospice, facility, and the Hospice patient and family to the extent possible. Hospice retains the primary responsibility for development of the plan of care.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure call lights were left in reach of residents. This affected one (Resident #41) of four residents reviewed for environmental concerns. The facility census was 42.Findings include:Record review of Resident #41 revealed she was admitted [DATE] with diagnoses including dementia, anxiety disorder, and chronic respiratory failure. Her Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she needed substantial assistance from staff for bed mobility.Observation of Resident #41 on 04/19/26 at 10:08 A.M. revealed her call light was hanging from the bed rail outside of her reach on the right side. The right side had three pillows stacked preventing her from reaching the cord to pull the call light up into reach.Interview with Registered Nurse (RN) #518 on 04/19/26 at 10:38 A.M. confirmed the above observation. Following surveyor intervention, she placed the call light within resident reach.This deficiency represents non-compliance investigated under Complaint Number 2726820.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews and facility policy review, the facility failed to ensure a clean, safe and homelike environment. This affected three (Residents #8, #29, and #36) of four residents reviewed for physical environment. The facility census was 42.Findings include:1. During an observation on 04/19/26 at 10:14 A.M., Resident #8's room had a large hole in the wall behind the head of the bed with multiple scrapes, scratches, and areas of missing paint. Walls, floors, and the nightstand surrounding the resident's room contained large brown- and yellow-colored dried splatter stains of unknown origin. The floor was visibly dirty and covered with food particles and debris. Interview on 04/19/26 at 10:20 A.M. with Registered Nurse (RN) #518 observed and verified the condition of Resident #8's room. 2. On 04/22/26 at 9:23 A.M., observation of Resident #29's room revealed the air conditioner unit's front cover was hanging off, and the vent cover was detached and lying on the floor. The floor had dirt marks and debris. A long curved gouge was present in the floor by the entrance door, caused by the door dragging. The door was very difficult to close. On 04/22/26 at 9:29 A.M., observation of Resident #36's room revealed the door was difficult to open. The floor was dirty with stains, dirt, and debris. The outlet supplying power to the television was missing its cover. The vent cover was partially detached. A small dent with crumbling wall material was observed above the baseboard near the room entrance. On 04/22/26 at 9:54 A.M., Director of Maintenance (DOM) #590 verified the door to Resident #36's room was hard to open, stating it had been removed previously to bring in a large bed. He stated the door could be repaired, but not immediately. DOM #590 also verified the missing outlet cover, the dented wall area, and the loose vent cover, stating he would address all items except the door, which would require additional time. On 04/22/26 at 9:58 A.M., DOM #590 verified conditions in Resident #29's room, including the difficulty closing the door and the resulting damage to the floor. He confirmed the AC unit cover and vent cover were off, stating the resident's bed had struck the units. On 04/22/26 between 10:08 A.M. and 10:20 A.M., the Housekeeping Supervisor (HSKS) #505 verified the floor conditions in Residents #29's and #36's rooms. HSKS #505 stated the facility had experienced staffing issues but was fully staffed that week and working to catch up. Reviewed policy Safe and Homelike Environment, revised 06/01/24 revealed housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. This deficiency represents non-compliance investigated under Master Complaint Number 2961312 and Complaint Numbers 1320285 (OH001320285), and 1320283 (OH00166923).

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, the facility failed to ensure the medical director attended the Quality Assessment and Assurance (QAA) and Quality Assurance and Performance (QAPI) meetings at least quarterly as required. This had the potential to affect all 42 residents residing in the facility.Findings include:Review of the monthly meeting sign-in sheets dated April 2025 through March 2026 revealed there was no signature for the medical director between April 2025 to June 2025 meetings. Interview on 04/29/26 at 2:03 P.M. with the Administrator and Regional Registered Nurse (RRN) #626 verified there were no signatures from the medical director between April 2025 through June 2025, which was the second quarter, to indicate the medical director was in attendance. Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI), revised 01/04/23, revealed the QAA committee shall be interdisciplinary and shall consist at a minimum of the director of nursing services; the medical director or his/her designee; at least three other members of the facility's staff, at least one of which must be the administrator, owner, a board member or other individual in a leadership role; and the infection preventionist. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary.