STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365837	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Manor	1670 Crider Rd Mansfield, OH 44903

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on medical record review, resident interview, observation, staff interview, and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected one (Residents #39) of three residents reviewed for medication administration. The facility census was 64 residents. Findings include: Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including parkinsonism, bipolar disorder, osteoarthritis, and depression. Review of the Minimum Data Set (MDS) assessment for Resident #39 dated 07/08/24 revealed the resident was cognitively intact. Review of the physician's orders for Resident #39 revealed an order dated 09/15/23 for Gabapentin (an anti-seizure medication) 600 milligram (mg) tablets three times daily. The order included entries indicating the medication was reordered on 07/23/24 and 07/24/24. Review of the Medication Administration Record (MAR) for Resident #39 dated July 2024 revealed the resident did not receive Gabapentin on 07/23/24 and 07/24/24. Review of the progress notes for Resident #39 dated 07/23/24 at 9:08 A.M., 12:30 P.M., and 4:21 P.M. revealed the resident's Gabapentin was not administered because the medication was not available. The notes did not include documentation regarding physician or pharmacy notification of the omitted doses on 07/23/24. The progress notes for Resident #39 dated 07/24/24 did not include documentation of the omitted doses of Gabapentin. Review of the facility list of medications available in the emergency kit, undated, revealed Gabapentin 300 mg capsules (quantity of 6) and Gabapentin 100 mg capsules (quantity of 6) were available for administration if needed. Review of Resident #39's electronic and physical medical record contained no evidence Gabapentin was removed from the emergency kit and provided to the resident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365837	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/30/24 at 11:01 A.M. with Resident #39 confirmed on 07/23/24 and 07/24/24 she missed all three routine doses of her Gabapentin. Resident #39 stated she asked her nurses multiple times where her medication was, and they said the medication had been reordered but was not in the facility. Observation on 07/31/24 at 7:35 A.M. with Assistant Director of Nursing (ADON) #204 revealed the facility's emergency kit was stored in the medication room behind the nurses' station. Review of the log associated with the emergency kit revealed no doses of Gabapentin had been signed out for Resident #39. Interview on 07/31/24 at 8:24 A.M. with ADON #204 confirmed Resident #39 missed six consecutive doses of Gabapentin on 07/23/24 and 07/24/24. ADON #204 further confirmed Resident #39's record did not include documentation of notification of the pharmacy or attending physician of the missed doses and staff had not signed out doses of Gabapentin from the emergency kit for Resident #39. Review of the facility policy titled Medication Errors Reporting - Pharmacy Related undated revealed errors included medications not administered within the allowed time frame, failing to administer an ordered dose, and administration of medication which is greater/lesser than what is ordered. Review of the facility policy titled Emergency Pharmacy Service and Emergency Kits dated 03/28/18 revealed medications should be administered as ordered by the provider. A list of all medications and supplies should be posted on the kit and system and should include medication, quantity, expiration date and the pharmacy name and phone number. A method of recording use of items from the emergency kit should be in place. This deficiency represents noncompliance investigated under OH00156258.

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NAME OF PROVIDER OR SUPPLIER Oak Grove Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1670 Crider Rd Mansfield, OH 44903	

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47990 Based on review of the facility menu, resident interview, staff interview, observation, review of the facility food temperature logs, and review of the facility policy the facility failed to ensure food temperatures were assessed to ensure safe ranges prior to resident consumption. This had the potential to affect all 64 residents in the facility who were identified by the facility to receive food from the facility kitchen. The facility census was 64 residents. Findings include: Review of the facility lunch menu dated 07/30/24 revealed the following items were listed: chicken parmesan, spaghetti noodles, cauliflower, garlic toast. Interview on 07/30/24 at 8:26 A.M. with Resident #23 confirmed the food at the facility was fair, sometimes the hot items were not hot enough for her liking. Interview on 07/30/24 at 10:13 A.M. with Staff Member (SM) #510 confirmed she heard food concerns from residents on a daily basis, including hot food items were not hot enough, food was too tough, and residents receiving food they did not order or items they disliked. Interview on 07/30/24 at 11:01 A.M. with Resident #39 confirmed sometimes when she got her meal tray, the food is lukewarm. The meat was of varying quality, sometimes too tough or chewy. Observation on 07/30/24 at 11:44 A.M. revealed [NAME] #242 and Dietary Manager (DM) #138 were at the steam cart in the kitchen preparing to serve the lunch meal. [NAME] #242 retrieved a calibrated food thermometer and proceeded to do her pre-meal food temperature checks. The chicken patty was 176 degrees Fahrenheit (F), the spaghetti noodles were 168 degrees F, and the cauliflower was 184 degrees F. [NAME] #242 did not record the temperatures on the designated food temperature monitoring log. [NAME] #242 and DM #138 did not obtain temperatures of the following items on the steam table: garlic toast, tomato sauce, mechanical soft chicken, pureed chicken, pureed noodles, pureed garlic bread, pureed cauliflower, green beans, hamburger patties. Further observation revealed [NAME] #242 and DM #138 did not obtain temperatures of pre-poured glasses of milk on approximately 50 resident meal trays. Interview on 07/30/24 at 11:48 A.M. with [NAME] #242 confirmed she typically only obtained temperatures of the main entrees prior to meal service. [NAME] #242 further confirmed she did not record the food temperatures for the main items she had temped. Interview on 07/30/31 at 12:53 P.M. with DM #138 following the conclusion of the lunch tray line confirmed [NAME] #242 should have checked food temperatures of all of the items on the steam stable prior to meal service to ensure they were at safe temperatures and [NAME] #242 should have checked the temperature of the milk and should have recorded all food temperatures on the log at this the temperatures were obtained. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Food Preparation and Storage revised November 2022, revealed the danger zone for food temperatures was above 41 degrees F and below 135 degrees F. This temperature range would promote the rapid growth of pathogenic microorganisms that cause foodborne illnesses. Potentially hazardous foods included meats, poultry, seafood, cut melon, eggs, milk, yogurt, and cottage cheese. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Proper hot and cold temperatures should be maintained during food distribution and service. The temperatures of foods held in steam tables should be monitored throughout the meal service by food and nutrition services staff. This deficiency represents noncompliance investigated under Complaint Number OH00155626.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to serve residents with orders for mechanically altered diets the proper textured diet as ordered by the physician. This affected three (Residents #11, #16, and #18) of 14 residents on a mechanically altered diets. The facility census was 64 residents. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, oral phase dysphagia, muscle weakness, and a complete loss of teeth. Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 07/12/24 revealed the resident had severely impaired cognition, required a mechanically altered diet and received set up assistance with eating. Review of the care plan for Resident #11 dated 07/16/24 revealed the resident had the potential for oral/dental health problems related to being edentulous (no natural tooth or tooth fragments present) and was at risk for malnutrition and dehydration. Interventions included to consult with the dietician for chewing and swallowing problems and to provide oral care as needed. Review of Resident #11's physician's orders revealed an order dated 04/04/22 for a mechanical soft diet. 2. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses included malnutrition, dementia, aphasia, dysphagia, following a cerebral vascular accident, muscle weakness. Review of the MDS assessment for Resident #16 dated 05/17/24 revealed the resident was cognitively impaired, required a mechanically diet, was edentulous, and required set up assistance with eating. Review of the physician's orders for Resident #16 revealed an order dated 04/10/24 for a diet of no added salt mechanical soft texture. 3. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including a history of cancer, asthma, schizoaffective disorder, gastroesophageal reflux disease (GERD) and mild intellectual disabilities. Review of Resident #18's physician's orders revealed an order dated 03/25/22 for the resident to receive a mechanical soft diet. Review of the MDS assessment for Resident #18 dated 07/03/24 revealed the resident had moderately impaired cognition, required a mechanically altered, and required set up assistance with meals. (continued on next page)

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/30/24 at 11:48 A.M. revealed [NAME] #242 prepared regular texture meal trays for Residents #11, #16, and #18. The entree was chicken parmesan which included a piece of breaded chicken on top of a plate of spaghetti with tomato sauce. The meal also included cauliflower and garlic toast. The tray tickets for Residents #11, #16, and #18 indicated these residents should be served a mechanically soft diet. At 11:55 A.M. Dietary Aide (DA) #134 began to wheel the meal cart out to the unit to serve the residents when the Surveyor intervened asked Dietary Manager (DM) #138 to check Resident #11, #16, and #18's meal trays for accuracy. DM #138 then discarded the entrees for Residents #11, #16, and #18, and prepared three new entrees which included spaghetti and mechanical soft (ground up) chicken with tomato sauce. Interview on 07/30/24 at 11:56 A.M. with DM #138 confirmed Residents #11, #16, and #18 had orders for mechanical soft textured diets and cook #242 had prepared entrees for these residents with regular textures. DM #138 confirmed if the Surveyor had not intervened the residents would have received the wrong textured diet for the lunch meal. Review of the facility policy titled Therapeutic Diets dated October 2017 revealed therapeutic diets were prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. A therapeutic diet was considered a diet ordered by a physician as part of treatment for a disease or clinical condition to modify specific nutrients in the diet or to alter the texture of a diet. This deficiency represents noncompliance investigated under Complaint Number OH00155626.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on medical record review, observation, staff interview, resident interview, and review of the facility policy, the facility failed to serve resident meals which honored the resident's preferences and accommodated resident allergies. This affected three (Residents #11, #16, and #18) of 14 residents on a mechanically altered diets. The facility census was 64 residents. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, oral phase dysphagia, muscle weakness, and a complete loss of teeth. Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 07/12/24 revealed the resident had severely impaired cognition, required a mechanically altered diet and received set up assistance with eating. Review of the care plan for Resident #11 dated 07/16/24 revealed the resident had the potential for oral/dental health problems related to being edentulous (no natural tooth or tooth fragments present) and was at risk for malnutrition and dehydration. Interventions included to consult with the dietician for chewing and swallowing problems and to provide oral care as needed. Review of Resident #11's physician's orders revealed an order dated 04/04/22 for a mechanical soft diet. 2. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses included malnutrition, dementia, aphasia, dysphagia, following a cerebral vascular accident, muscle weakness. Review of the MDS assessment for Resident #16 dated 05/17/24 revealed the resident was cognitively impaired, required a mechanically diet, was edentulous, and required set up assistance with eating. Review of the physician's orders for Resident #16 revealed an order dated 04/10/24 for a diet of no added salt mechanical soft texture. 3. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including a history of cancer, asthma, schizoaffective disorder, gastroesophageal reflux disease (GERD) and mild intellectual disabilities. Resident #18 had a listed allergy to tomatoes. Review of Resident #18's physician's orders revealed an order dated 03/25/22 for the resident to receive a mechanical soft diet. Review of the MDS assessment for Resident #18 dated 07/03/24 revealed the resident had moderately impaired cognition, required a mechanically altered, and required set up assistance with meals. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/30/24 at 11:55 A.M. revealed Dietary Manager (DM) #138 prepared the meals for Residents #11, #16, and #18 which included spaghetti with ground up chicken and tomato sauce with cauliflower and garlic toast on the side. Interview on 07/30/24 at 2:52 P.M. with Resident #18 confirmed the only thing she ate off her lunch tray was the cake because she was allergic to tomatoes and tomato sauce covered her chicken and spaghetti noodles. Resident #18 stated no one offered her a replacement meal. Interview on 07/30/24 at 2:59 P.M. with DM #138 confirmed Resident #11's tray ticket listed tomatoes, tomato sauce and spaghetti as disliked foods. DM confirmed Resident #16's tray ticket listed cauliflower and spaghetti as disliked foods. DM #138 confirmed Resident #18's tray ticket listed an allergy to tomatoes. Dietary Manager #138 confirmed the tray tickets and meals provided to Residents #11, #16, and #18 did not honor the residents' allergies and/or preferences. Review of the facility policy titled Therapeutic Diets dated October 2017 revealed therapeutic diets were prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. A therapeutic diet was considered a diet ordered by a physician as part of treatment for a disease or clinical condition to modify specific nutrients in the diet or to alter the texture of a diet. This deficiency represents noncompliance investigated under Complaint Number OH00155626.