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	10/29/2024

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 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** 31638 Based on medical record review, resident family interview, staff interview, orthopedic staff interview, review of hand written statements, review of the facility incident and accident log, and policy review, the facility failed to investigate an injury of unknown origin as required. This affected one (#24) of three residents reviewed for abuse, neglect, mistreatment, exploitation, and misappropriation. The facility census was 67. Findings included: Review of Resident #24's medical record revealed an admitted [DATE]. Diagnoses included infection and inflammatory reaction due to an internal left knee joint prosthesis, periprosthetic fracture around internal prosthetic right hip joint, atrial fibrillation, transient ischemic attack, and muscle weakness. Review of Resident #24's clinical admission note dated 10/17/24 revealed the resident required use of a wheelchair and knee immobilizer. She had a range of motion impairment of one unspecified lower extremity. Resident #24's gait was documented as unsteady and balance was poor. Staff were to maintain proper joint alignment while turning and positioning. Review of Resident #24's admission note dated 10/17/24 revealed a knee immobilizer to left leg was in place. Review of Resident #24's fall risk assessment dated [DATE] revealed the resident was at a high risk for falls. Review of Resident #24's medical record found no mention of a fall or injury noted from the date of admission until 10/25/24. Review of the facility incident and accident log revealed no falls or injuries were log for Resident #24 between 10/17/24 and 10/25/24. Review of a hand written statement dated 10/22/24, written by Registered Nurse (RN) #165 revealed Resident #24 and a certified nurse aide (CNA) were in the bathroom when RN #165 entered to administer medications. Further review of the written statement revealed Resident #24 indicated her knee popped and was given pain medication. Resident #24 was administer additional pain medication 30 minutes later and then denied any further pain or issues. (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's health status note dated 10/25/24 revealed the resident returned from an orthopedic physician appointment and the facility was then notified by the orthopedic office that the facility needed to send Resident #24 to the local hospital as a direct admission due to several femur fractures. Interview with Resident #24's family member on 10/29/24 at 9:10 A.M. revealed on 10/22/24 the resident informed the family that a CNA was assisting her to the bathroom when the resident's and CNA's legs became entangled in each other and the resident twisted her leg. The CNA sat Resident #24 on the toilet and the resident was in intense pain. Interview with the Director of Nursing (DON) on 10/29/24 at 8:23 A.M. revealed she was aware that Resident #24 bumped her leg in the bathroom but verified the chart was free of documentation regarding the incident. Interview with the DON and the Administrator on 10/29/24 at 11:05 A.M. revealed the facility did not initiate an investigation into Resident #24's femur fracture, and the DON stated she thought the resident's femur fracture was present on admission. Telephone interview with Orthopedic Nurse (ON) #160 on 10/29/24 at 11:08 A.M. revealed Resident #24 did not have a femur fracture prior to admission to the facility. ON #160 stated the fracture was identified on an x-ray during the resident's first post-operative appointment on 10/25/24. ON #160 stated the orthopedic surgeon's office then notified the facility of the femur fracture and requested Resident #24 be brought to the hospital for treatment. Interview with RN #165 on 10/29/24 at 11:10 A.M. revealed on 10/22/24 she witnessed Resident #24 with a CNA in the bathroom. The resident was sitting on the toilet and told RN #165 she heard something pop when her feet got tangled. The resident was assessed for pain and administered pain medication. The rest of the day Resident #24 denied pain until the nurse went off her shift. Interview with CNA #116 on 10/29/24 at 1:05 P.M. revealed on 10/22/24 she was assisting Resident #24 to the bathroom when the resident's foot got tangled up in her boot and it twisted her leg. CNA #116 sat the resident down on the toilet and untangled her legs. At that point the resident was crying in pain and the nurse was right outside the door and came and assessed her. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/06/22, revealed it is the facility's policy to investigate all alleged violations of abuse, neglect misappropriation of resident property, exploitation or mistreatment, including injuries of unknown source. All incidents of injuries of unknown source must be reported immediately to the Administrator or designee and the Ohio Department of Health (ODH). Once notification is made, and investigation of the alleged violation will be conducted. This deficiency represents an incidental finding discovered during investigation of Master Complaint Number OH00159311.

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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. 31638 Based on observation, staff interview, review of a cleaning task list, and policy review, the facility failed to store food in a safe and sanitary manner and failed to ensure food service equipment, storage areas, and kitchen floor were properly cleaned. This had the potential to affect all 67 residents. The facility census was 67. Findings included: 1. Observation of the kitchen on 10/24/24 at 9:55 A.M. with Dietary Aide #134 revealed walk-in cooler #1 was full of boxes. The boxes were stored directly on the floor inside the cooler and staff were unable to walk into the cooler due to the amount of boxes stacked four to five boxes high. Interview with Dietary Aide #134 at the time of the observation revealed the facility received the food delivery the day before and no one had time to unpack the boxes. Dietary Aide #134 verified the boxes containing food items were stored directly on the cooler floor. Review of the undated policy titled, Food Storage, revealed all refrigerated food should be stored off of the floor. 2. Observation of the kitchen on 10/29/24 at 7:50 A.M. revealed the shelf under the steam table was dirty with food crumbs and areas of dried brown and white liquid. The flooring near the walls in the dish room was observed to have a build up of dirt and some debris. Further observation revealed the bottom shelf of the clean dish rack had a thick layer of dust build up. Interview on 10/29/24 from 7:52 A.M. to 8:10 A.M. with Dietary Manager #119 verified the dirty dish room floor near the walls specifically near under the dishwasher, the dirty shelving under the steam table, and the dirty dish rack for clean pots and pans. Review of an undated cleaning task list revealed staff are to sweep and mop the dish room and under equipment daily, clean work tables and decrease clutter underneath daily, and dust pot and pan shelves as needed but at least weekly. Review of the policy titled, Cleaning and Sanitation of Dining and Food Services Areas, dated 2023, revealed the food and nutrition services staff will maintain the cleanliness and sanitation of the dining room and the food service areas through compliance with a written, comprehensive cleaning schedule This deficiency represents non-compliance investigated under Complaint Number OH00158146. 41528

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41528 Based on observation, staff interview, and review of a facility policy, the facility failed to maintain a pest free environment. This had the potential to affect all 67 residents. The census was 67. Findings include: 1. Observation on 10/28/24 at 10:00 A.M. revealed the dish washer room in the kitchen had, at minimum, four to five gnats and a fly. Further observation of the kitchen serving area revealed a fly was present in the area. Interview on 10/28/24 at 10:05 A.M. with Dietary Manager #119 verified the gnats and flies in the kitchen. 2. Observation on 10/29/24 at 9:30 A.M. revealed Resident #10 was sitting in a chair in his room. When Resident #10 moved, five (5) flies flew off of him. Interview on 10/29/24 at 9:32 A.M. with the Administrator verified the number of flies in Resident #10's side of the room. The Administrator removed the bag of garbage from the end of the resident's bed; however, no flies were observed near the garbage. Interview on 10/29/24 at 9:48 A.M. with Resident #23 revealed there are often flies in his room. Review of a policy titled, Pest Control Policy, dated August 2016, revealed the facility acknowledged the importance of pest and vermin control in providing a living environment of adequate health and safety for its residents. This deficiency represents non-compliance investigated under Complaint Number OH00158146 and Complaint Number OH00157659.