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	12/23/2024

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 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. 34298 Based on observation and interviews, the facility failed to ensure residents had water at the appropriate temperature in their bathrooms. This affected three (Residents #3, #4, and #6) out of three reviewed for water temperatures. Facility census was 59. Findings include: Review of an invoice dated 10/16/24 revealed a fifty-gallon hot water tank was ordered. Review of a typed timeline provided by Maintenance Supervisor #104 revealed he was notified the hot water heater for Resident #3's room blew the seams out of the back. An order was placed for a new hot water heater. The new hot water heater was delivered late in the afternoon of 10/16/24. Maintenance Supervisor #104 installed the new hot water heater on 10/17/24. According to the timeline on 11/15/24, Maintenance Supervisor #104 was notified of the high limit switch and the breaker for the new hot water tank were tripping frequently. Maintenance Supervisor #104 replaced the upper thermostat on 11/15/24. On 11/22/24, Maintenance Supervisor #104 was notified that the water was cold again. Maintenance Supervisor #104 found the bottom heating element had burnt out. On 11/22/24, Maintenance Supervisor #104 replaced the heating element. On 12/09/24, the water was getting cold again and the bottom thermostat was replaced. Review of the water temperature logs for 10/23/24 and 11/13/24 revealed the rooms for Resident #3, #4, and #6, did not have water temperatures recorded. Review of the water temperature log for 12/09/24 revealed the rooms for Resident #3, #4, and #6, did not have water temperatures recorded. Interview on 12/23/24 at 10:04 A.M. Resident #4 stated the water in her bathroom would start to get warm and then would get cold. Resident #4 stated she would like to have hot water so she could take a bath in the tub in her bathroom. The water in the bathroom sink was turned on and started to feel warm but then felt cool. Interview on 12/23/24 at 11:23 A.M. Resident #6 verified there had been a problem with hot water. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/23/24 at 11:34 A.M. Resident #3 verified there had been problems with hot water. A new hot water tank had been installed but the water did not stay hot. Resident #3 stated they had showered in their bathroom and had to finish their shower in cold water. Resident #3 stated they had bought their own shower chair so they could take showers in their personal bathroom and not go to the main shower room. The water in the bathroom sink was turned on. The water started to feel warm but then felt cool. Observation of water temperatures with Maintenance Supervisor #104 on 12/23/24 at 2:02 P.M. revealed the water in Resident #4's room reached 96 degrees Fahrenheit (F) and then started to drop. At 2:05 P.M. the water temperature in Resident #3's room was 98.2 degrees F and started to drop. At 2:07 P.M. the water in Resident #6's room was 92.7 degrees F. Maintenance Supervisor #104 verified the water temperatures for Resident #3, #4, and #6 were controlled by the same hot water tank and were not at the appropriate temperature. Maintenance Supervisor #104 found the mixing valve was at 100 degrees. When Maintenance Supervisor #104 tried to adjust the mixing valve, he discovered the valve was seized up. Maintenance Supervisor #104 called a plumbing company to bring a new mixing valve. The plumbing company said they would be out either late 12/23/24 or first thing 12/24/24. Maintenance Supervisor #104 also verified there was no documentation of water temperatures being checked in Resident #3, #4, and #6's rooms since October 2024. Review of the resident council meeting minutes for 11/11/24 revealed there was no hot water on the 400 hall. The concern was resolved by working with a plumber to get a new hot water heater. This deficiency represents non-compliance investigated under Complaint Number OH00160270.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observation, record review, and interview, the facility failed to ensure treatments were put in place in a timely manner. This affected three (Residents #3, #6, and #7) of three residents reviewed for wounds. Facility census was 59. Findings include: 1. Review of the medical record revealed Resident #3 was admitted on [DATE] with diagnoses that included acquired absence of bilateral legs, peripheral vascular disease, chronic obstructive pulmonary disease, and chronic pain syndrome. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was cognitively intact and had Moisture Associated Skin Damage (MASD). A skin condition/shower sheet dated 11/06/24 revealed Resident #3 had an open area that appeared to be an abrasion. Resident #3 requested to have an appointment made at the dermatologist. A skin monitoring/shower review sheet dated 11/12/24 revealed Resident #3 had an abrasion to buttock. Resident #3 did not want to see the facility Certified Nurse Practitioner (CNP). On 11/13/24 an order was received to cleanse bilateral buttocks with wound cleanser, pat dry, and apply triad (zinc-oxide based paste used on light to moderate wound exudate) paste every shift due to shearing. Review of the Treatment Administration Record (TAR) revealed the treatment was started on 11/13/24. On 11/19/24 a weekly wound assessment revealed Resident #3 had shearing to right gluteal fold that measured 0.5 centimeters (cm) long and 0.5 cm wide. A health status note dated 11/20/24 at 1:44 P.M. revealed per Resident #3's request a dermatology appointment was made for skin breakdown to gluteal area. The earliest appointment available was 12/09/24. Interview on 12/23/24 at 11:34 A.M. Resident #3 verified a treatment and appointment to the dermatologist was not done in a timely manner. Resident #3 stated the area to buttock was sore, but the paste seemed to help. Observation on 12/23/24 at 11:46 A.M. revealed Resident #3 had white colored paste to buttocks and peri area. A small open area with a red wound bed was noted to Resident #3's left gluteal area. Interview on 12/23/24 at 3:22 P.M. with Assistant Director of Nursing (ADON) #105 verified the abrasion to Resident #3's buttock was discovered on 11/06/24. ADON #105 verified there was no documentation of the physician being notified or a treatment order being put in place until 11/13/24 (seven days later). ADON #105 also verified Resident #3 requested to see a dermatologist on 11/06/24 and an appointment was not made until 11/20/24. Resident #3 was first seen by the dermatologist on 12/09/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/23/24 at 5:49 P.M. the Director of Nursing (DON) verified the physician was not notified, orders were not put in place, and dermatology appointment was not done in a timely manner for Resident #3. 2. Review of the medical record revealed Resident #6 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, vascular dementia, and Parkinsonism. The annual MDS dated [DATE] revealed Resident #6 was cognitively intact. A weekly wound assessment dated [DATE] revealed Resident #6 had a newly identified venous ulcer to the right lower extremity that measured 3 cm long, 1.5 cm wide, and 0.1 cm deep. The treatment plan order included the wound to be cleansed with wound cleanser, patted dry, and calcium alginate with silver (wound dressing where silver acts as an antimicrobial and the alginate absorbs wound fluid) applied, covered with a super absorbent gauze and six-inch ace bandage to base of the knee. The treatment was ordered daily and as needed. A health status note dated 12/17/24 at 3:08 P.M. revealed Resident #6 was seen by the wound CNP. Wounds to bilateral lower extremities were cleansed and measured. The area to the right lower extremity was considered a reopened venous wound. Treatment was applied. Review of the December TAR revealed no evidence of the treatment to the right lower extremity being put in place or completed as ordered. Interview on 12/23/24 at 5:51 P.M. the DON verified the order and treatment for Resident #6's right lower leg was not put in place until 12/23/24. 3. Review of the medical record revealed Resident #7 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included Parkinsonism, chronic pain, palliative care, and type 2 diabetes. The quarterly MDS dated [DATE] revealed Resident #7 had severe cognitive impairment. The weekly wound assessment dated [DATE] revealed Resident #7 had a new wound. The wound was classified as a Stage II (partial-thickness skin loss involving the epidermis and dermis) pressure ulcer to sacrum that measured 3.5 cm long, 3 cm wide, and 0.1 cm deep. The treatment plan was to cleanse sacrum with wound cleanser, pat dry, and apply triad cream every shift and as needed. Review of the December TAR revealed no evidence of the treatment to the sacrum being put in place or completed as ordered. Interview on 12/23/24 at 3:16 P.M. ADON #105 verified the order and treatment for Resident #7 was not put in place until 12/23/24. This deficiency represents non-compliance investigated under Complaint Number OH00160270 and OH00160226.