

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  09/25/2025
NAME OF PROVIDER OR SUPPLIER  Oak Grove Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, resident and staff interviews, and review of the facility policy, the facility failed to ensure medical appointments were timely scheduled as physician ordered. This affected one (Resident #36) of two residents reviewed for appointments. The facility census was 75. Findings include: Review of the medical record for Resident #36 revealed an admission on [DATE]. Diagnoses included chronic ischemic heart disease and acute diastolic (congestive) heart failure (CHF). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was cognitively intact. Review of the care plan dated 08/18/25 revealed Resident #36 had altered cardiovascular status related to CHF and hypertension. Interventions included monitoring and reporting to medical providers any signs and symptoms of chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in capillary refill, color or warmth of extremities. Review of the progress note dated 05/26/25 revealed Resident #36 was having shortness of breath and chest pain. The facility called a triage Nurse Practitioner (NP), and the NP spoke to Resident #36 via video call. The NP determined Resident #36 did not need to be sent to the emergency room. The NP progress note dated 05/27/25 revealed Resident #36 was seen for chest pain and dizziness. An electrocardiogram (EKG) was ordered as well as follow up with cardiologist based on findings. The progress note dated 05/28/25 at 11:45 A.M. revealed new orders for Resident #36 to have an EKG due to orthostatic blood pressure and consultation with cardiology. The progress notes dated 07/28/25 revealed the facility faxed Resident #36's consultation to cardiology on 07/08/25 and 07/28/25. There was no evidence in Resident #36's medical record that a cardiology appointment was scheduled nor seen by a cardiologist from 05/28/25 to 09/23/25. During an interview on 09/24/25 at 8:59 A.M., Resident #36 revealed she was waiting to see a cardiologist due to having CHF. Resident #36 stated a couple months ago, the Director of Nursing (DON) told Resident #36 she needed to see a cardiologist, but the appointment had not been made. Interview on 09/24/25 at 9:37 A.M. with Transportation Aide (TA) #304 revealed prior to starting the position of appointments and transportation in June 2025, the facility had issues with residents missing appointments. TA #304 stated Resident #36 had a referral to cardiology; however, there were issues with cardiology receiving the referral from the facility. TA #304 confirmed that since 07/28/25, no further attempts were made to make the appointment. Interview on 09/24/25 at 9:50 A.M. with the DON confirmed Resident #36 should have had a cardiology consult scheduled due to concerns of chest pain, shortness and diagnoses of CHF. Review of the facility policy titled Transportation dated 04/28/25 revealed the facility staff will receive the appointment from the resident, family, transportation company or doctors' office. The staff will schedule transportation to and from the appointment as needed. This deficiency represents non-compliance investigated under Complaint Number 2604984.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on record review, observation, staff interview, resident interview, and review of the facility policy, the facility failed to ensure food was palatable and appropriate temperature. This had the potential to affect all 75 residents residing in the facility who receive food from the kitchen. Findings include: Review of the resident council meeting for 09/08/25 revealed residents did not like most of the food due to having the same food, dry meat, and food not being seasoned. Under the area that reads status update on the resident council minutes revealed the concern was not resolved. Interview on 09/24/25 at 1:39 P.M. with Resident #53 revealed breakfast was always cold so he no longer eats breakfast. Resident #53 stated he has reported it to the Certified Nursing Assistants (CNAs); however, nothing has changed. Resident #53 stated the CNAs would offer to reheat the food; however that was not preferred. Interview on 09/24/25 at 2:00 P.M. with Resident #4 revealed the food was frequently cold by the times the trays were passed. Resident #4 stated she eats the food because she was hungry, however she would prefer her food to be warmer. Observation on 09/25/25 at 7:30 A.M. revealed Dietary Manager (DM) #529 taking food temperatures for breakfast. Temperature of sausage patties were 172 degrees Fahrenheit (F), waffles were 136 degrees F, and oatmeal was 165 degrees F. Observation on 09/25/25 at 7:55 A.M. revealed the hallway trays being transported to the 100-hallway. Trays began being distributed at 8:01 A.M. with the last tray being passed at 8:11 A.M. The last hallway tray temperature was obtained and revealed the sausage patties were 101 degrees F, and the waffles were 88 degrees F. A test tray was obtained at this time from DM #529. The sausage patty was lukewarm and was dry, and difficult to swallow. The waffles were cool to taste and dry as well. Interview on 09/25/25 at 8:20 A.M. with DM #529 confirmed the sausage and waffles were not warm and the sausage patties were dry. DM #529 stated they used to use plate warmers; however, the machine was too hot for the staff to handle. DM #529 stated special gloves were supposed to be ordered for staff to use but were never followed through. Interview on 09/25/25 at 11:15 A.M. with the Administrator revealed the staff should have been using plate warmers to keep the food warm. Review of the facility policy titled Food Temperatures dated 2021 revealed hot food items may not fall below 135 degrees F after cooking. Temperatures should be taken periodically to ensure hot foods stay above 135 degrees F during the holding and plating process. This deficiency represents non-compliance investigated under Complaint Number 2604984 and Complaint Number 2565327.</p>		