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	05/16/2024

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 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** 16453 Based on observation, medical record review, and resident and staff interviews, the facility failed to provide one (#71) of 17 sampled residents reasonable accommodations of needs and preferences to enhance the ability to perform self-mobility. The facility census was 70. Findings include: Review of Resident #71's medical record identified admission to the facility occurred on 04/08/24 with medical diagnoses including morbid obesity, congestive heart failure, high blood pressure, diabetes, and chronic kidney disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #71 was cognitively intact and required partial/moderate assistance with rolling. Review of Resident #71's physician orders dated 04/13/24 revealed an order for bilateral bed mobility bars to facilitate independence with bed mobility. Observation and interview with Resident #71 occurred in the resident's while the resident was in bed on 05/15/24 at 2:12 P.M. Resident #71's bed was observed without assist bars installed to the bed. Resident #71 identified she had been asking for grab bars to be added to her bed since admission to the facility to assist her in being able to turn over in the bed. Resident #71 stated she was told the facility ordered the grab bars, however, they have not been installed and it had been longer than a month since she was told. Interview with Maintenance Director #44 occurred on 05/15/24 at 2:33 P.M. and confirmed Resident #71's bed did not have grab bars installed and he currently did not have any in the facility to place on the bed.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 16453 Based on medical record review and resident and staff interview, the facility failed to ensure one (#38) of five residents reviewed for advanced directives were consistent throughout the medical record. The facility census was 70. Findings include: Review of Resident #38's medical record identified admission to the facility occurred on 09/18/20 with medical diagnoses including congestive heart failure (CHF), edema, pain, morbid obesity, and diabetes. Review of Resident #38's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with moderately impaired cognition. Review of Resident #38's physician orders dated 03/25/24 revealed an order for the resident to be a Full Code (full life-saving measures in the event of cardiac or respiratory arrest) status for advanced directive. Review of Resident #38's current plan of care revealed the resident wished to have a Do Not Resuscitate - Comfort Care (DNR-CC; only comfort measures to be administered in the event of cardiac or respiratory arrest) advanced directive in the event of cardiac or respiratory arrest. The plan of care and intervention to review the resident's advanced directive as part of quarterly annual, admission, readmission, significant change assessments, care conferences, or as needed. Interview on 05/15/24 at 9:02 A.M. with Resident #38 stated she did not want life-saving measures preformed in the event her heart would stop or she would stop breathing. Interview with Licensed Practical Nurse (LPN) #82 confirmed the current physician orders for Resident #38 identified the resident had an order to be a Full Code and a care plan to be DNR-CC. Further interview with LPN #82 stated she could not locate any evidence of on-going evaluation of Resident #38's code status. This deficiency represents non-compliance investigated under Complaint Number OH00153898.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Keep residents' personal and medical records private and confidential. 16453 Based on resident interview and staff interview, the facility failed to ensure mail was delivered to residents on Saturdays. This affected nine (#3, #7, #17, #27, #33, #41, #52, #53, and #56) of nine residents interviewed regarding mail delivery and had the potential to affect all 70 residents residing in the facility. The census was 70. Findings include: Interview on 05/15/24 at approximately 10:00 A.M. with nine (#3, #7, #17, #27, #33, #41, #52, #53, and #56) residents during a Resident Council meeting revealed multiple concerns were expressed that residents were not receiving mail on Saturdays. The residents reported mail was delivered to the business office, sorted, and then distributed to residents by the activities department. The residents reported the business office was typically open Monday through Friday, so mail that was delivered to the facility on Saturday was never distributed to residents within 24 hours of delivery. During an interview on 05/15/24 at 10:40 A.M., Activities Assistant #41 reported the activities department staff were in charge of distributing mail to residents on the days they worked. Activities Assistant #41 verified mail was delivered to the business office on Saturdays and the business office was typically closed on Saturdays. Activities Assistant #41 verified activities staff had to wait for the business office to return to the facility to sort through the mail so it could then be distributed to residents. Activities Assistant #41 also verified mail received by the facility on Saturdays was not normally delivered the same day.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 16453 Based on observation, resident and staff interviews, and review of a concern log, the facility failed to maintain comfortable sounds levels in the facility. This has the potential to affect nine (#3, #7, #17, #27, #33, #41, #52, #53, and #56) of nine residents who voiced concerns regarding the sound levels in the facility. The facility census was 70. Findings include: Observation at the nursing station, which was located in the center of the four units in the facility was completed on 05/15/24 at 7:10 A.M. The observation identified there was a very loud alarm that sounded anytime the door to the patio where residents who smoke go outside was opened. The alarm and panel was located at the front of the nursing station and was very loud. The alarm was heard going off multiple times on 05/15/24 including at 7:14 A.M., 7:18 A.M., and 7:20 A.M. The observation identified there are currently four unidentified residents who are not interviewable located at the nursing station and appeared annoyed at the ongoing sound. Interview with Resident #3 was completed on 05/15/24 at 1:57 P.M. Resident #3 confirmed she was the Resident Council president and stated the residents at the council meetings have complained regarding the smoking door alarm for a long time and nothing has changed. The interview with Resident #3 confirmed the alarm was obnoxious and loud, and there were resident complaints that the alarm woke them up from sleeping at times. Interview with Maintenance Director (MD) #44 occurred on 05/14/24 at 12:20 P.M. The interview confirmed the loud alarm was for the doors in the facility that lead to outside. The interview confirmed there was no way to turn the sound down nor turn it off when the doors are opened. The interview confirmed there have been complaints from residents regarding the alarm. MD #44 confirmed staff have to go to the nursing station to actually turn off the alarm for the doors. Interviews were completed with nine (#3, #7, #17, #27, #33, #41, #52, #53, and #56) residents who attended the Resident Council meeting on 05/15/24 at 10:30 A.M. All nine residents complained about the very loud alarm that was going off all the time at the nursing station. The interview confirmed the alarm was going off all the time and was so loud it was annoying and could wake residents up from sleeping sleeping. Review of the facility concern log identified there were residents complaints of the loud alarm back to January 2024. Interview with the Administrator on 05/15/24 at 10:57 A.M. confirmed the residents told her about their concerns regarding the very loud alarm. The interview confirmed there was a company who came to the facility and identified there was no way to turn the alarm down.

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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. 16453 Based on medical record review, resident and staff interview, review of self-reported incidents (SRIs), and policy review, the facility failed to ensure alleged perpetrators were identified in reports of abuse allegations submitted to the State Survey Agency. This affected one (#30) of two residents reviewed for abuse. The facility census was 70. Findings include: Review of Resident #30's medical record identified admission to the facility occurred on 08/08/22 with medical diagnoses including non-stemi myocardial infarction, anemia, hypertension, generalized weakness, depression, obesity, and hypokalemia. Interview with Resident #30 on 05/13/24 at 8:26 A.M. stated Stated tested Nurse Aide (STNA) #92 was rough with her care and she reported it to the facility. Resident #30 stated the facility did an investigation and asked her questions regarding the incident. Review of the facility's SRI submitted to the State Survey Agency on 04/09/24 identified an allegation of abuse was made by Resident #30. The facility reported the incident as required; however, the facility omitted STNA #92 as the alleged perpetrator in the reporting system. Interview with Social Services Director (SSD) #90 on 05/14/24 at 1:29 P.M. confirmed she was part of the investigation for Resident #30's abuse allegation and confirmed the facility did not list STNA #92 as the alleged perpetrator in the SRI submitted to the State Survey Agency. Review of the facility abuse policy, dated 07/20, revealed an immediate investigation is warranted when suspicion of abuse or reports of abuse occur. This includes identifying and interviewing all persons involved including the alleged perpetrator and providing complete and thorough documentation of the investigation. The procedure included reporting of all alleged violations to the state agency within specified timeframes.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on observation, medical record review, resident representative interview, staff interview, and review of scheduled activities, the facility failed to ensure residents were offered or assisted in attending activities and failed to provide activities as scheduled. This affected six (#3, #17, #27, #41, #46, and #53) of nine residents reviewed for participation in activities. The facility census was 70. Findings include: 1. Review of the activity calendar for May 2024 revealed on 05/15/24 the facility would provide a detective activity at 2:00 P.M. and a daily walk outside at 3:00 P.M. Observation on 05/15/24 from 1:57 P.M. to approximately 2:30 P.M. revealed five (#3, #17, #27, #41, and #53) residents were sitting in the dining area where scheduled activities in the facility were planned to take place. Further observation revealed there were no staff in the area and no organized activities were taking place. Interviews at the time of observation revealed numerous random residents reported they were unsure if the detective activity was going to occur as scheduled and reported no staff members informed them w of any changes to the activity schedule. The residents further reported it was not uncommon for a scheduled activity to not occur. Observation on 05/15/24 at approximately 2:30 P.M. revealed Resident #3, Resident #17, Resident #27, Resident #41, and Resident #53 started to leave the dining area. During an interview on 05/15/24 at 3:40 P.M., Activities Director (AD) #51 verified the detective activity and the daily walk did not occur as scheduled. During an interview on 05/15/24 at 4:28 P.M., the Administrator verified a staff member should have informed residents the activities were not occurring as scheduled. 2. Review of the medical record for Resident #46 revealed an admitted [DATE] a diagnosis of dementia. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46's preferences for routines and activities was assessed and revealed it was somewhat important to do her favorite activities and do things with groups of people. Review of the care plan dated 11/30/23 for Resident #46 revealed she was at risk for alteration in activity participation as she had cognitive impairment and was dependent on staff for activities. Review of the activity assessment dated [DATE] for Resident #46 revealed she required reminders and extensive verbal cues for activities. Resident #46 needed large BINGO cards and someone to remind her when BINGO was scheduled. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/13/24 at 1:06 P.M. with Resident #46's son revealed the resident liked to go to activities but staff failed to remind her and she could not remember due to her impaired memory. Review of the activity calendar on 05/14/24 at 1:40 P.M. revealed BINGO was scheduled on 05/14/24 at 2:00 P.M. Observation on 05/14/24 at 1:41 P.M., 1:50 P.M., and 2:06 P.M. revealed Resident #46 was in her room lying on her bed. Observation on 05/14/24 at 2:15 P.M. revealed an activity (BINGO) in the dining room with activity staff present. Interview on 05/14/24 at 2:10 P.M. with State tested Nurse Aide (STNA) #40 verified Resident #46 was in her room lying on her bed. STNA #40 stated when activity staff worked it was their responsibility to go and ask the residents to go to BINGO, not the nurse aides or nurses. Interview on 05/14/24 at 3:54 P.M. with Activities Assistant (AA) #41 revealed there were activity calendars on the bulletin board. AA #41 stated the nurse aides needed to review the activities and assist the residents who wished to participate. AA #41 stated she was unable to assist Resident #46 out of bed as she was not an STNA, and AA #41 confirmed Resident #46 liked BINGO and did well with the activity. This deficiency represents non-compliance investigated under Complaint Number OH00152383. 43063

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure the activities program is directed by a qualified professional. 44454 Based on personnel file review, staff interview, and review of a job description, the facility failed to ensure the activities program was directed by a qualified individual as required. This had the potential to affect all residents who resided in the facility with the exception of two (#32 and #60) residents who the facility identified as not participating in activities. The facility census was 70. Findings include: Interview on 05/16/24 at 11:23 A.M., with Activities Director (AD) #51 confirmed the staff member did not have the certification, experience, or education required to be the director of the facility's activities program. AD #51 also verified they were not licensed or registered. AD #51 stated the facility would be providing the training for AD #51 to become a certified activities program director. Review of the personnel record for AD #51 revealed AD #51 did not have a certification to be an activities director or the appropriate training and/or education to hold the position of activities director. During an interview on 05/16/24 at 12:22 P.M., the Administrator confirmed AD #51 did not meet the qualifications to direct the facility's activities program. The Administrator stated the previous activities director was terminated from employment and AD #51 was moved into their current role on 05/13/24. The Administrator stated AD #51 would begin training to be qualified for the role of activities director, but confirmed AD #51 was not currently enrolled in any programs and a date to begin a training program had not been established. Review of the job description titled, Activities Director, revealed certification in accordance with regulatory agencies is required. This deficiency represents non-compliance investigated under Complaint Number OH00152383.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on medical record review, resident and staff interview, review of emergency medication availability lists, and review of an emergency medication policy, the facility failed to provide an as needed medication from the emergency supply for one (#3) of five residents reviewed for medications. The facility census was 70. Findings include: Review of Resident #3's medical record identified admission occurred on 10/19/17 with medical diagnoses including asthma and bipolar disorder. Review the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was assessed with no cognitive impairment. Review of Resident #3's nursing progress notes identified at 6:43 P.M. on 05/14/24 the resident requested a respiratory assessment be completed. The assessment completed at that time identified no concerns. Further review of the progress notes revealed a note dated 05/15/24 at 3:14 P.M. identified a nurse called the pharmacy and requested a refill of Resident #3's inhaled bronchodilator medication Ventolin inhaler and was told it would be delivered at 11:00 P.M. that evening. Review of Resident #3's physician orders revealed an order dated 07/16/21 for Ventolin 90 micrograms per inhalation with instructions to administer two puffs inhaled every four hours as needed. Interview with Resident #3 occurred on 05/15/24 at 2:10 P.M. Resident #3 revealed she asked for her as needed inhaler last night and was told there was not one to give her. Resident #3 stated medications not being available when she needed them was a concern. Interview with Licensed Practical Nurse (LPN) #82 was completed on 05/16/24 at 8:21 A.M. The interview confirmed the staff did not pull Resident #3's as needed Ventolin inhaler from the emergency medication supply when she requested it, and instead called the pharmacy to let them know she did not have any in the facility. The interview confirmed the nursing staff should first check the emergency medication supply if medications were unavailable in the medication cart. LPN #82 confirmed the nursing staff should pull medications that are unavailable in the medication cart from the emergency medication supply when the medication is needed immediately. Review of the undated facility listing of emergency medications available identified a Ventolin inhaler was available in the facility. Review of the facility's undated emergency medications supplies policy identified when a medication is needed from the emergency supply, remove the appropriate medication complete a usage communication form, retaining the white copy for your records, and placing the yellow copy at the top of the box. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00153898 and Complaint Number OH00152383.

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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** 49793 Based on medical record review and resident and staff interview, the facility failed to ensure residents were free from significant medication errors. This affected one (#59) of five residents reviewed for medications. The facility census was 70. Findings include: Review of the medical record for Resident #59 revealed an admitted [DATE]. Diagnoses included absence of right below the knee amputation status post gangrene, type two diabetes with hyperglycemia, chronic obstructive pulmonary disease with acute exacerbation, major depressive disorder, unspecified dementia with mood disturbances, anemia, delirium due to psychosis. Review of the medical record and physician's order for Resident #59 revealed and order dated 04/22/24, that identified a change in dosage of the antipsychotic Abilify from two (2) milligrams (mg) to five (5) mg. The order was received and acknowledged by Licensed Practical Nurse (LPN) #82. The order transcribed by LPN #82 on 04/22/24 was inadvertently discontinued. Review of Resident #59's medication administration records (MARs) for April and May 2024 revealed the times scheduled for Abilify 5 mg once daily by mouth that was scheduled to increase the dosage dated 04/23/24 to 05/15/24 was not administered. Review of a certified nurse practioner (CNP) progress note dated 05/10/24 revealed per a previous visit, Resident #59's Abilify was to be increased but instead was discontinued. There were not reports of psychosis, anxiety, behavioral disturbances, or aggression reported. The CNP documented the Ability will be restarted for Resident #59. Interview with LPN #73 on 05/16/24 at 9:24 A.M. revealed there was a medication error when LPN #82 received and took an order to discontinue Resident #59's Abilify 2 mg and did not initiate the new order for the medication to be increased to 5 mg. LPN #73 stated it appeared LPN #82 discontinued the order completely. Interview with Resident #59 on 05/16/24 at 1:34 P.M. stated he experienced not significant changes in his mental health related to the issue with his Abilify. This deficiency represents non-compliance investigated under Complaint Number OH00153898.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Dispose of garbage and refuse properly. 44454 Based on observation and staff interview, the facility failed to ensure garbage and refuse was disposed of properly. This had the potential to affect all 70 residents residing in the facility. The census was 70. Findings include: During an observation on 05/13/24 at approximately 8:10 A.M., with Dietary Supervisor #55, two exterior facility dumpsters were observed with trash laying on the ground around the dumpsters. The trash included a potato bag, a chip bag, an empty applesauce container, a disposable glove, soup cans, bread wrappers, jelly packet wrappers, water and pop bottles, cookie wrappers, a used brief, a disposable plastic cup, sandwich wrappers, and a chicken nugget carton from a local fast-food chain. Further observation revealed unidentified animal track marks could be seen throughout the mud located near the dumpsters. During an interview at the time of the observation on 05/13/24, Dietary Supervisor #55 verified the debris on the ground around the dumpster and stated the facility had issues with raccoons.

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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 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** 43063 Based on medical record review and staff interview, the facility failed to ensure accurate documentation in the medical record when wound care treatments, prevention devices, and supplement orders were administered. This affected one (#66) of two residents reviewed for wounds. The facility census was 70. Findings include: Review of the medical record for Resident #66 revealed an admitted [DATE] with diagnoses including displaced fracture of the left femur, diabetes mellitus, and anxiety. Review of the physician's orders for Resident #66 revealed an order dated 03/02/24 to cleanse the surgical site, staples, and sutures on the left hip with normal saline, pat dry, and leave open to air every night shift. Further review revealed an order dated 03/26/24 for the resident to have podus boots (boots used for heel pressure injuries) on when in bed as tolerated every shift for prevention, and an order dated 05/04/24 for house liquid protein twice a day for wound healing in the morning and at bedtime. Review of the medication administration record (MAR) and treatment administration record (TAR) for April 2024 and May 2024 for Resident #66 revealed podus boots were not documented as being on the resident as ordered on 04/03/24 and 04/08/24 on dayshift and at night on 04/13/23 and 04/17/24; house liquid protein was not documented as administered as ordered on 05/04/24, 05/05/24, 05/06/24, 05/07/24, and 05/08/24. The order to cleanse Resident #66's surgical site to the left hip was documented by nursing staff as being completed daily from 04/01/24 through 05/12/24. Interview on 05/14/24 at 2:33 P.M. with Licensed Practical Nurse (LPN) #73 verified Resident #66's left hip surgical site had healed at the end of March 2024, however she could not recall the exact date. LPN #73 stated the physician's order for cleaning the surgical site should have been discontinued and verified the nursing staff was still signing off a treatment that was no longer being performed as the area was healed. Interview on 05/16/24 at 8:43 A.M. with Registered Nurse (RN) #93 verified nursing staff did not document accurately when house liquid protein and podus boots were administered as ordered for the aforementioned dates. This deficiency represents non-compliance investigated under Complaint Number OH00153898 and Complaint Number OH00152383.