STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366008	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Pointe Healthcare Commu	Three Merit Dr Richmond Heights, OH 44143

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to complete wound treatments as ordered by the physician. This affected one resident (#114) of three residents reviewed for wound care. The facility census was 140. Findings include:Review of the medical record for Resident #114 revealed an initial admission date of 08/20/24 and re-entry date of 03/18/15. The resident had been hospitalized from [DATE] to 03/18/25 for a wound infection. Diagnoses included polyosteoarthritis, dementia, adult failure to thrive, left-hand and right-hand contractures, left and right shoulder contractures, and severe protein-calorie malnutrition.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #114 had severely impaired cognition and four venous/arterial ulcers. Review of a wound assessment report dated 03/25/25 revealed Resident #114 had a left elbow wound due to end-of-life skin failure, and arterial ulcers to the right hallux (big toe), right heel, left hallux, and left heel.Review of physician orders dated 05/05/25 revealed Resident #114 was admitted to hospice services due to cerebral atherosclerosis with a life expectancy of less than sixth months.Review of a wound assessment report dated 06/02/25 revealed Resident #114 had a sacral/buttocks wound and a left elbow wound due to end-of-life skin failure, and arterial ulcers to the right heel, right hallux, left heel, and left hallux. Review of the physician orders for April 2025 revealed Resident #114 had treatments ordered to the left hallux, left heel, right hallux and right heel arterial ulcers. The left hallux, left heel, and right heel treatments were to cleanse with normal saline solution (NSS), apply betadine (an antiseptic solution), cover with an abdominal (ABD) dressing then wrap with gauze daily on night shift. The right hallux treatment was to cleanse with NSS, apply silver alginate (a dressing used for wounds at risk of or showing signs of infection), cover with an ABD dressing then wrap with gauze daily on night shift. Review of the Treatment Administration Record (TAR) for April 2025 revealed Resident #114's ordered wound treatments were not documented as completed on 04/05/25, 04/17/25, 04/20/25 and 04/25/25. Review of the physician orders for May 2025 revealed Resident #114 had treatments ordered to the left elbow wound and left hallux, left heel, right hallux and right heel arterial ulcers. The left elbow treatment was to cleanse with NSS, apply silver alginate, then cover with a border gauze dressing daily on day shift. The left hallux, left heel, right hallux, and right heel treatments were to cleanse with NSS, apply betadine, cover with an ABD dressing then wrap with gauze three times weekly on night shift. On 05/14/25, the left hallux, left heel, right hallux, and right heel treatments were changed and stated to cleanse with NSS, apply betadine, then leave open to air daily on night shift. Review of the TAR for May 2025 revealed Resident #114's left elbow treatment was not documented as completed on 05/23/25. The treatments to Resident #114's left hallux, left heel, right hallux, and right heel were not documented as completed on 05/03/25 or 05/24/25. Review of the physician orders for June 2025 revealed Resident #114 had treatments ordered to the sacrum/buttocks wound, the left elbow wound, and the left hallux, left heel, right hallux and right heel arterial ulcers. The sacrum/buttocks treatment was to cleanse with NSS, apply silver alginate, cover with a sacral foam dressing, then apply Calmoseptine (a moisture barrier) to the peri-wound (skin surrounding the wound) daily on night shift. The left elbow treatment was to cleanse with NSS, apply silver alginate, then cover with border gauze dressing daily on day shift. The left hallux and left heel treatments were to cleanse with NSS, apply betadine and leave open to air three times weekly on night shift. The right hallux and right heel treatments were to cleanse with NSS, apply betadine, cover with an ABD dressing, and wrap with gauze three times weekly on night shift. On 06/12/25, the right hallux treatment was changed to cleanse with NSS, apply betadine then leave open to air three times weekly on night shift. Review of the TAR for June 2025 revealed Resident #114's sacrum/buttock wound was not documented as completed on 06/12/25, 06/14/25, 06/15/25, 06/21/25 and 06/24/25. Resident #114's left elbow treatment was not documented as completed on 06/06/25. The left hallux treatment was not documented as completed on 06/05/25, 06/12/25, 06/14/25, 06/21/25 and 06/24/25. The left heel treatment was not documented as completed on 06/05/25, 06/14/25, 06/21/25 and 06/24/25. The right heel treatment was not documented as completed on 06/05/25, 06/14/25, 06/21/25 and 06/24/25. The right hallux treatment was not documented as completed on 06/05/25, 06/14/25, 06/21/25 and 06/24/25.Review of nursing progress notes from April 2025 to June 2025 revealed no evidence Resident #114's wound treatments were completed as identified in the above findings. Interview on 07/07/25 at 9:25 A.M. with Director of Nursing verified Resident #114's wound treatments were not completed as ordered by the physician as identified in the above findings Review of

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to timely implement physician orders to insert an indwelling urinary catheter. This affected one resident (#145) of three residents reviewed for urinary tract infection (UTI) prevention. The facility census was 140.Findings include: Review of the medical record for Resident #145 revealed an admission date of 03/20/25 and discharge date of 04/01/25. Diagnoses included orthopedic aftercare, closed fracture of the lower end of left femur, closed fracture of the lateral condyle of left femur, closed fracture of the medial condyle of left femur, fracture of the ninth and tenth thoracic vertebra, and atrial fibrillation. A diagnosis of retention of urine was added upon the date of discharge on [DATE].Review of Resident #145's undated profile sheet revealed the resident was listed as his own responsible party with two children both listed as emergency contacts.Review of the nursing progress notes from 03/20/25 to 03/24/25 revealed Resident #145 was admitted to the facility for skilled therapy services due to a fall which resulted in a left femur fracture. The resident was oriented, able to make needs known, and had no complaints or concerns.Review of Resident #145's physician orders dated 03/25/25 indicated for routine laboratory testing to include a CMP (comprehensive metabolic panel) and for a post-operative orthopedic appointment on 04/01/25.Review of the Nurse Practitioner (NP) progress note dated 03/25/25 revealed Resident #145 had no acute pain and routine laboratory testing was pending. Review of a laboratory test collected on 03/26/25 revealed a high BUN (blood urea nitrogen) level and low GFR (glomerular filtration rate) which both values were used to assess kidney function.Review of the NP progress note dated 03/27/25 revealed Resident #145 denied any changes with bladder function. The laboratory test collected 03/26/25 which resulted in a low GFR indicated stage four chronic kidney disease, so nephrology was to be consulted for evaluation.Review of a laboratory test collected on 03/27/25 again revealed Resident #145 had a high BUN level and low GFR. Review of a nursing progress note dated 03/27/25 revealed the nephrologist was contacted regarding Resident #145's kidney function, and ordered an ultrasound of the kidneys, a bladder scan with PVR (post-void residual) [a measure of the amount of urine remaining in the bladder immediately after urination] and a urinalysis with culture and sensitivity (UA/ CS) [to test for a urinary tract infection] due to the elevated BUN level.Review of Resident #145's physician order dated 03/27/25 revealed to collect a urine specimen for UA/CS, a bladder scan with PVR, and an ultrasound of the kidneys due to the elevated BUN level. The corresponding Treatment Administration Record (TAR) for March 2025 indicated the ultrasound was completed on 03/28/25.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #145 had moderately impaired cognition and was frequently incontinent of urine. Resident #145 did not have an indwelling urinary catheter.Review of a nursing progress note dated 03/28/25 revealed Resident #145's ultrasound of the bladder and kidneys was completed, including the PVR which resulted in 703 milliliters (mL) of urine left in the bladder after voiding. The nephrologist ordered a Foley catheter (an indwelling urinary catheter) to be inserted.Review of Resident #145's physician order dated 03/28/25 indicated to insert a Foley catheter due to PVR of 703 mL and to change the foley catheter and drainage bag as needed every shift. The corresponding TAR for March 2025 indicated the Foley catheter was inserted on 03/28/25 night shift but no urine specimen had yet been obtained as ordered. Review of the electronic medication administration note dated 03/29/25 at 3:06 P.M. indicated Resident #145 did not have a foley catheter in place as was indicated on the TAR as placed on 03/28/25. There was no indication the physician was contacted.Review of a nursing progress note dated 03/29/25 at 11:02 P.M. revealed Resident #145 was straight catheterized (a urinary catheter used to drain the bladder and not designed to remain in the bladder for extended periods) which drained 1250 mL of urine, and a urine specimen was collected and placed into a refrigerator. There was no documented evidence of urinary discomfort or communication with the physician. The corresponding TAR for March 2025 indicated the urine specimen was collected on 03/29/25 night shift.Review of the electronic medication administration note dated 03/30/25 at 9:27 P.M. indicated Resident #145 continued to have no Foley catheter in place. There was no indication the physician was contacted.Review of a primary care physician progress note dated 03/31/25 revealed Resident #145 denied blood in the urine, difficulty urinating, and had no frequent urination. There was no evidence in the documentation of the physician being aware of the nephrologist's orders for an indwelling urinary catheter to be placed, or that there was a delay in executing those orders. Review of a nursing progress note dated 03/31/25 at 3:09 P.M. revealed Resident #145 had a Foley catheter