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	10/27/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure a physician order for a pressure ulcer treatment was transcribed into the electronic medical records. This affected one resident (#136) of three residents reviewed for physician orders. The facility census was 151.Findings include:Review of Resident #136 ' s medical record revealed an admission date of 02/04/25. Diagnoses included a stage four pressure ulcer (a full thickness wound involving muscle, tendon, and/or bone involvement) to the sacrum (tailbone area), stroke with right sided weakness, and malnutrition.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #136 had intact cognition. Resident #136 was dependent on staff for toileting, bathing, and personal hygiene. Review of the care plan dated 09/18/25 revealed Resident #136 had an actual skin impairment. Interventions included a negative pressure wound vac set at 125 millimeters of mercury (mmHg) of pressure and change the wound vac dressing three times a week on every Tuesday, Thursday, and Saturday, and as needed. Review of Resident #136 ' s physician orders for October 2025 revealed to change wound vac dressing three times a week on Tuesdays, Thursdays and Saturdays and as needed. Physician orders had not included specific information regarding the type of dressing or treatments.Review of a progress note dated 10/17/25 authored by Wound Nurse Practitioner (WNP) #355 revealed orders that included cleanse the sacral area with Dakins (antiseptic) solution, apply skin prep and stoma paste, apply a transparent drape to the area, cut black foam to fit the wound area and apply a transparent dressing over the black foam and set the wound vac to negative 125 mmHg continuously every Tuesday, Thursday, and Saturday.Interview on 10/21/25 at 3:00 P.M. with Registered Nurse (RN) #230, who was the facility's wound nurse, confirmed WNP #355 ' s orders had not been transcribed into his medical records and stated specific wound care orders should have been included in Resident #136 ' s physician orders. Review of the facility policy titled Physician Orders undated revealed physician orders will be transcribed into the electronic medical records.This deficiency represents non-compliance investigated under Complaint Number 2645034.

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

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	10/27/2025

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Grande Pointe Healthcare Commu	Three Merit Dr Richmond Heights, OH 44143

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure appropriate infection control techniques were used during incontinence care. This affected one resident (#136) of two residents observed for incontinence care. The facility census was 151.Findings include:Review of Resident #136's medical records revealed an admission date of 02/04/25. Diagnoses included stroke with right sided weakness, muscle weakness, and malnutrition.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #136 had intact cognition. Resident #136 was dependent on staff for toileting and was incontinent of bowel and bladder. Review of the care plan dated 09/18/25 revealed Resident #136 was dependent on staff for toileting. Interventions included to check the resident for incontinence.Observation of incontinence care on 10/20/25 at 10:57 A.M. with Certified Nursing Assistant (CNA) #255 revealed Resident #136 was incontinent of liquid stool. CNA #255 had proceeded to provide Resident #136 with incontinence care while wearing gloves. Upon completion of incontinence care CNA #136 had not removed her soiled gloves and had then proceeded to apply Vaseline to Resident #136's arms and legs using the same soiled gloves she had used to provide incontinence care. Interview with CNA #255 at time of observation revealed she should have removed the soiled gloves after completion of incontinence care. This deficiency represents an incidental finding identified during the complaint investigation.