

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Manor of Grande Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2610 East Aurora Road Twinsburg, OH 44087	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096</p> <p>Based on record review, observation, and interview the facility failed to ensure call lights were within reach of Residents #37 and #176. This affected two residents (#37 and #176) of 73 residents residing at the facility.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including multiple sclerosis, heart failure, dementia, depressive disorder, acute kidney failure, Parkinson's, and difficulty walking.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 had intact cognition and required moderate assistance of staff for eating, bed mobility, transfers, and hygiene.</p> <p>Review of the care plan dated 04/26/24 revealed Resident #37 had a history of falls related to Parkinson's, weakness, and dementia. Intervention included keeping the call light within reach.</p> <p>Observation on 06/30/24 at 9:45 A.M. of Resident #37 revealed she was lying in bed, and her call light was lying on the floor next to her bed. Interview at this time with Certified Nursing Assistant (CNA) #508 verified the call light was out of reach and stated the resident was able to use her call light. CNA #508 stated Resident #37 was not on her assignment.</p> <p>2. Review of the medical record for Resident #176 revealed an admitted [DATE] with diagnoses including Parkinson's, schizoaffective, epilepsy, dementia, obesity, and anxiety.</p> <p>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #176 had intact cognition and impairment to one side. The resident required set up with eating and was dependent for transfers and bed mobility. The resident was dependent on staff for toileting and showers.</p> <p>Review of the care plan dated 06/20/24 revealed Resident #176 was at risk for falls related to weakness and seizures. Intervention included using call light for assistance.</p> <p>(continued on next page)</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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Observation on 06/25/24 at 11:49 A.M. of Resident #176 revealed she was lying in bed, and her call light was lying on the nightstand next to her bed on top of several stuffed animals. The call light was out of her reach. Interview with Resident #176 stated CNA #508 and State tested Nurse Aide (STNA) #586 changed her earlier today. The call light was placed on the nightstand by staff during care. Staff forgot to put it back within reach prior to leaving.</p> <p>Interview on 06/25/24 at 12:06 A.M. with STNA #586 verified Resident #176's call light was out of reach and sitting on her nightstand. STNA #586 stated Resident #176 and was not on her assignment.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333</p> <p>Based on record review and interview, the facility failed to ensure Resident #29's code status was accurately reflected in both the hard medical chart and the electronic medical record. This affected one resident (#29) of 73 residents reviewed for advanced directives. The facility census was 73.</p> <p>Findings include:</p> <p>A review of Resident #29's hard medical chart revealed he was admitted to the facility on [DATE] with diagnoses of heart failure, end stage renal disease, and hypothyroidism. A document with the words, Full Code, was located on the face sheet in the electronic chart. A full code status means all emergency life saving measures will be provided in the event of respiratory arrest or cardiac arrest.</p> <p>Review of Resident #29's medical record dated 01/03/24 located in the hard chart revealed a code status of Do Not Resuscitate-Comfort Care Arrest (DNR-CCA). A DNR-CCA means a person would receive all emergency and medical care up until the time he or she experiences a cardiac or respiratory arrest, then all lifesaving measures would be stopped.</p> <p>Interview on 06/30/24 at 2:21 P.M. with Licensed Practical Nurse (LPN) #546 verified that the electronic chart showed Resident #29 as a Full Code, and the hard chart showed Resident #29 had a DNR-CCA.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>35768</p> <p>Based on observation and interview, the facility failed to ensure Insulin KwikPens and insulin vials were dated when opened. This affected three residents (#3, #7, and #226) of twelve residents who were identified by the facility as receiving insulin. The facility census was 73.</p> <p>Findings include:</p> <p>Observation on 06/30/24 at 11:19 A.M. of a medication cart revealed two KwikPens not dated when opened, for Residents #3 and #7, and one used insulin vial not dated when opened for Resident #226. Interview at the time of the observation, Registered Nurse (RN) #530 stated all insulin pens should be dated when initially opened during the observation.</p> <p>Review of the facilities policies and procedures revealed no policy for insulin storage. This was verified by the Director of Nursing on 07/01/24 at 3:35 P.M.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>39333</p> <p>Based on observation, interview, taste test and pureed/mechanical soft guidelines review, the facility failed to serve pureed foods at a smooth consistency for safe swallowing. This had the potential to affect four residents (#1, #22, #46, and #58) who were prescribed pureed diets of 73 residents who consumed meals from the facility's kitchen. The facility census was 73.</p> <p>Findings include:</p> <p>Observation and interview on 07/01/24 at 10:45 A.M. revealed [NAME] #566 pureed hamburgers, and they were the proper consistency. [NAME] #566 then pureed the French fries and portioned a sample into a monkey dish for the taste test. The French fries were contained lumps and were not a smooth consistency. Regional Dietary Manager #600 verified on 07/01/24 at 11:00 A.M. and stated [NAME] #566 should puree the French fries more. The French fries were pureed correctly prior to service. The facility identified four residents (#1, #22, #46, and #58) who were prescribed pureed diets.</p> <p>Review of the facility's pureed/mechanical soft guidelines revealed pureed foods should be pureed until smooth.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39333</p> <p>Based on observations, interview, and facility policy review the facility failed to ensure the kitchen was clean and sanitary. This had the potential to affect all 73 residents that received meals from the facility. No residents were identified as receiving nothing by mouth. The facility census was 73.</p> <p>Findings include:</p> <p>Observation during a tour of the kitchen on 06/30/24 from 8:10 A.M. to 8:30 A.M. with [NAME] #566 revealed Dietary Aide (DA) #601 had a full beard with no beard net on while in the kitchen. DA #601 stated on 06/30/24 at 8:10 A.M. that he should have been wearing a beard net.</p> <p>Observation of the walk-in refrigerator revealed salad mix not labeled or dated, meatballs in a pan with a ripped foil cover, and a half of an undated cucumber. The door to the dining room and plate warmer had food splatter and food residue on it. The identified findings were verified at the time of observations with [NAME] #566.</p> <p>A revisit to the kitchen for tray line observation on 07/01/24 revealed that one food cart was dirty with food splatter on the door and inside. This was verified by Regional Dietary Manager #600 at 11:40 A.M. Further observation on 07/01/24 at 11:45 A.M. revealed the ceiling had grease and mold on it near the fan. This was verified by Regional Dietary Manager #600 during observation.</p> <p>Review of the undated facility policy titled, Sanitation and Food Handling, revealed that sanitary conditions will be maintained, and personnel will observe cleanliness and exercise food handling techniques.</p>