STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366395	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks of Brecksville	8757 Brecksville Road Brecksville, OH 44141

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview, review of self-reported incidents (SRI), review of facility incident log, review of a local police report, review of Board of Nursing (BON) records, review of Board of Pharmacy records, and review of facility investigations, the facility failed to ensure residents were free from misappropriation. This affected five residents (#11, #29, #37, #41, and #85) out of five residents reviewed for potential misappropriation. The facility census was 75. Findings include: Review of the facility's incident log for February 2025 revealed there had been possible controlled medication misappropriation for Residents #11, #29, #37, #41, and #85. (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a police report dated [DATE] timed 11:58 A.M. revealed the facility had notified the police that 13 bottles of morphine solution and one Fentanyl (narcotic pain patch) were reported as missing. Upon police arrival, the former Administrator stated on [DATE] at approximately 12:00 P.M., the former Director of Nursing (DON) was vomiting inside the nursing office, appeared to have been under the influence, and had been taken home by an employee. On [DATE] at approximately 10:30 A.M. the former Administrator had requested the DON come into the facility. Upon the DON's arrival at the facility, she informed the DON there was reasonable suspicion (for substance use) based on her behaviors the prior day, and she would need to submit to a urine drug screen on-site at the facility. The DON complied, and the results of the rapid urine drug screen revealed a positive result was returned for morphine, oxycodone (a narcotic pain medication), and benzodiazepines (a class of anti-anxiety medications). The DON was made aware of the positive result and her employment was suspended at that time. During the suspension the Administrator and Regional Registered Nurse (RRN) #304 conducted an audit of the controlled substance narcotic drawer in the DON's office and discovered empty morphine boxes and narcotic count sheets that were missing the medications themselves. It was determined the [NAME] was the only staff member who had keys to the office where the medications were kept. The police report further stated a follow up call was placed to the police by the Administrator on [DATE] at 9:20 A.M. and the local police had been advised of additional discrepancies that were discovered after the initial report. The report noted the DON was noted to be enrolled at a treatment facility out of state. The police report noted the DON's employment with the facility was terminated on [DATE] with reasons including failed drug screen and theft-misappropriation. The police report referenced files provided by the former Administrator to the local police department via subpoena which revealed missing narcotics from 2023 to 2025, which included in 2023 there were 122 unspecified missing items, in 2024 there were 244 unspecified missing items, and in 2025 there were 55 unspecified missing items. The report further identified that between 2023 and 2025, there were 184 missing doses of oxycodone, 97 missing doses of Tramadol (a narcotic pain medication), and 54 missing doses of morphine. The police report referred to an interview conducted with the former DON on [DATE] which stated a friend had provided her with narcotics, which had then turned into abuse. The DON referenced the availability of narcotics at work and admitted to theft of oxycodone, morphine, and tramadol with the DON having stated she preferred oxycodone. The former DON stated she had obtained the medications from non-active orders from residents and stated she had abused medications at home but denied being impaired at work. The former DON admitted she had falsified destruction records while reporting them to the pharmacy that the destructions had been completed. Review of an email sent from the former DON to the former Administrator dated [DATE] timed 11:57 A.M. revealed on [DATE], the former DON had claimed she was ill; however, it was not related to taking any sort of narcotics. The DON confirmed she had taken narcotics when a resident had been discharged or no longer had an active order and denied taking any medications from active residents. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility Self-Reported Incident (SRI) dated [DATE] revealed the prior Administrator discovered potential misappropriation by the former Director of Nursing (DON). The SRI noted that on [DATE], a possible instance of drug diversion of Resident #11's morphine sulfate solution (a narcotic pain medication) was identified. The SRI noted the controlled substance record and an empty box of morphine (without the medication itself) was discovered in the former DON's office. Upon further review, the morphine had not been documented as being destroyed per protocol. During the investigation, additional concerns for diversion were identified for four additional residents (#29, #37, #41, and #85), where controlled substance records and controlled substances packaging were located in the former DON's office without the medications themselves. The conclusion of the facility's SRI had a disposition of unsubstantiated due to evidence being inconclusive, but that misappropriation was suspected. Review of a Board of Pharmacy Investigation dated [DATE] revealed the former DON was hired on [DATE]. The investigation stated the former DON had removed discontinued medication cards, deceased residents' medication cards, or discharged residents' medication cards. There was no set schedule as to when the former DON would remove discharged residents' or discontinued medication cards from the medication carts. The investigation noted the DON had signed the shift-to-shift count sheets with another nurse when medication cards were removed from the medication carts, and the pharmacy had requested the drugs to be destroyed within 30 days of removal from the medication carts. The facility was under the impression the pharmacy had been checking the drug destruction logs quarterly to ensure the destruction was completed properly. The investigation revealed a lack of documentation for the drug destruction logs, as the logs were only signed by the former DON and lacked a witness of the medication destruction. At the time of inspection by the Board of Pharmacy, 80 bottles of morphine, 186 medication cards of oxycodone, 21 medication cards of hydrocodone (a narcotic pain medication), 103 cards of Tramadol, and 67 other unspecified controlled substances were suspected to have been diverted due to lack of destruction documentation. Review of the board action by the Ohio Board of Nursing dated [DATE] revealed the former DON's license was suspended as she admitted to diverting and self-administering a lot of controlled substances over approximately the last year while employed as the facility's DON. The board action included the former DON's confirmation that she had falsely notified the pharmacy that medications were destroyed and that she had diverted resident medications for her own personal gain. An interview on [DATE] at 2:12 P.M. with RRN #304 revealed she had been made aware of suspicions of the DON being impaired while working at the facility in February 2025. RRN #304 stated the former Administrator had called her and stated on [DATE], the former DON was observed to have been vomiting in her office, her speech was slurred, and she was unsteady while standing. RRN #304 advised the former Administrator to contact the Human Resources (HR) department for further guidance. RRN #304 stated the DON had returned to the facility the following day ([DATE]), submitted to a urine drug test which came back positive for morphine and other controlled substances. RRN #304 stated the former DON was immediately placed on a suspension and an investigation began. RRN #304 stated the facility had immediately contacted the local police, the nursing board, and the pharmacy board who also began investigations. RRN #304 stated she and the former Administrator observed multiple empty medication cards of tramadol, oxycodone, and empty boxes of morphine. RRN #304 stated during the investigation, the DON may have been taking narcotics since sometime in 2023. RRN #304 stated there had not been any prior suspicions of the DON being under the influence or diverting medications prior to February 2025. RRN #304 stated the facility had not identified or reported any discrepancies related to narcotics. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Disposal of Medications revised [DATE] revealed the facility should destroy controlled substances in the presence of a Registered Nurse and another licensed professional. Controlled medications should be documented on the controlled medication count sheet by the Registered Nurse and witnessed by a licensed professional. The destruction process should include recording the quantity destroyed, date of destruction, and signature of both the Registered Nurse and licensed professional on a medication disposition/destruction form or on the Omniview drug destruction application. The facility should dispose of discontinued medications left in the facility after a resident has been discharged or deceased in a timely manner, no more than 90 days after the date the medication was discontinued. Review of the facility policy titled Ohio Resident Abuse Policy revised [DATE] revealed the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. The policy defined misappropriation as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. In the case of staff-to-resident abuse, neglect, involuntary seclusion, or misappropriation of resident property, the facility will follow facility's procedure for disciplining or dismissing an employee depending on the circumstances and results of the investigation. The facility will report the results of the investigation to the appropriate licensing agencies and registries in accordance with the law. The deficient practice was corrected on [DATE] when the facility implemented the following corrective actions: - On [DATE] at 10:45 A.M., the former DON submitted to an on-site urine drug screen. The urine drug screen came back positive for morphine, oxycodone, and benzodiazepines. - On [DATE] at 11:00 A.M., the former DON was suspended pending the outcome of the investigation by RRN #304. - On [DATE], the pharmacy and the local police department were notified by RRN #304. - On [DATE], the facility's Medical Director was notified by the former Administrator. - On [DATE], RRN #304 audited all current narcotic count sheets. The audits consisted of ensuring narcotics were appropriately secured, accounted for, and doses were signed off on the controlled substance records and recorded on the Medication Administration Record (MAR). There were no additional concerns identified. - On [DATE], RRN #304 completed an audit of all four facility medication carts to ensure medications were appropriately secured and accounted for. There were no negative findings. - On [DATE], an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the interdisciplinary team to discuss the drug diversion by the former DON. - On [DATE], RRN #304 completed an audit of prior narcotic destruction logs with identified concerns. The concerns were appropriately communicated to the pharmacy and local law enforcement as part of an ongoing investigation by RRN #304. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On [DATE] and again on [DATE], RRN #304 educated the new DON and Assistant Director of Nursing (ADON) on the facility's disposal and destruction of expired or discontinued controlled medications procedures. - On [DATE], RRN #304 and designees completed interviews with all interviewable residents to ensure residents were receiving their medications, including pain medications, as ordered. There were no negative findings. - On [DATE], RRN #304 completed interviews with all interviewable residents on quality of care and services and abuse, neglect, and misappropriation. There were no identified concerns. - On [DATE], RRN #304 and designees physically assessed all non-interviewable residents. The residents were assessed for verbal and/or nonverbal reports of pain with no negative findings. There were no concerns for abuse, neglect, or misappropriation. - On [DATE], RRN #304 and designees completed staff interviews regarding medication storage and administration processes. There were no concerns identified. - On [DATE], RRN #304 and designee educated all licensed nurses on proper destruction of controlled substances, drug diversion, ensuring narcotic count sheets matched quantity on hand and administration record, shift-to-shift narcotic count procedures, and the facility's policy on abuse, neglect, and misappropriation. Ongoing education would be provided to newly hired nurses by the DON or designee. - On [DATE], RRN #304 educated the facility's consultant pharmacist on auditing facility disposal and destruction of expired or discontinued controlled medications. - Beginning on [DATE], the new DON or designee conducted random audits of narcotic sheets to ensure there were no concerns for drug diversion weekly for four weeks, then monthly for two months. The results of the audits would be reported to the facility's QAPI committee for further review and recommendations. - Beginning on [DATE], the new DON or designee conducted interviews with five residents who received narcotic medications to ensure they received their medications appropriately weekly for four weeks, then monthly for two months. The results of the audits would be reported to the facility's QAPI committee for further review and recommendations. - Beginning on [DATE], the Administrator or designee monitored the narcotic drawer in the new DON office to ensure controlled substance destruction was completed timely weekly for four weeks, then monthly for two months. The results of the audits would be reported to the facility's QAPI committee for further review and recommendations. - On [DATE], the consultant pharmacist was present at the facility and destroyed all controlled substances per protocol. - The former DON was formally terminated from employment on [DATE]. This deficiency represents non-compliance investigated under Master Complaint Number OH00166891.

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on closed medical record review, review of hospital discharge paperwork, facility policy review and interview, the facility failed to ensure wound care orders were transcribed and implemented per physician's orders to promote healing and prevent infection for a surgical wound Resident #81 had upon admission to the facility. Actual Harm occurred on 05/26/25 when staff identified Resident #81 had not been provided wound care treatments to a surgical wound to the resident's back resulting in the infection. Resident #81 had been admitted on [DATE] with a dehisced surgical wound to the lower back and orders for wound care that were not implemented for six days (until 05/26/25). As a result, Resident #81's surgical wound was observed with purulent drainage (thick, malodorous wound drainage that is indicative of infection) and the presence of slough (dead, non-viable tissue, formed when cells in the wound bed die and accumulate, which impedes wound healing) in the wound bed. The resident was placed on an oral antibiotic on this date to treat the infection. On 05/30/25 the resident was assessed to be lethargic and was transferred to the hospital. The resident did not return to the facility. This affected one resident (#81) of three residents reviewed for wound care. The facility census was 75. Findings include: Review of Resident #81's closed medical records revealed an admission date of 05/21/25. Resident #81 had diagnoses including stable burst fracture of the fifth lumbar vertebra and uterine cancer. Resident #81 was transferred to a local hospital on [DATE] and did not return to the facility. Review of Resident #81's hospital discharge paperwork dated 05/21/25 revealed an order to cleanse Resident #81's right lower back surgical wound with vashe (antiseptic wound cleanser), apply aquacel AG advanced (an antimicrobial dressing with silver, commonly used on wounds that are infected or at risk to become infected), and cover with a mepilex (foam border dressing) daily and as needed . The resident was not on any antibiotic therapy upon admission to the facility. Review of an admission report sheet dated 05/21/25 authored by Registered Nurse (RN) #225 revealed Resident #81 had a surgical incision that had dehisced (incision that had opened after surgery). Review of an admission observation entry dated 05/21/25 authored by RN #225 revealed Resident #81 had a lumbar surgical dehisced wound. Review of Resident #81's physician's orders in the electronic medical record revealed an order dated 05/22/25 to keep the resident's lumbar surgical site clean and dry. The order further stated the site may be covered with a dry dressing and to monitor the site for signs and symptoms of infection once daily. Review of the Medication Administration Record (MAR) dated May 2025 revealed Resident #81's order dated 05/22/25 to keep the lumbar surgical site clean and dry was signed off as completed by nursing staff from 05/22/25 to 05/26/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan dated 05/22/25 revealed Resident #81 was at risk for skin breakdown. Interventions included to report any signs of red or broken areas. An update to the care plan dated 05/27/25 revealed Resident #81 had an infection and was on antibiotic therapy. Interventions included to monitor the resident's skin site for infection. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 had intact cognition and was dependent on staff for toileting, bathing, and personal hygiene. The assessment revealed Resident #81 was incontinent of bowel and bladder. Review of a progress note dated 05/26/25 timed 4:28 P.M. authored by RN #259 revealed she had entered Resident #81's room and a malodor was detected. RN #259 had assessed Resident #81 and had observed Resident #81's lumbar wound dressing was saturated with a serous (thin, watery wound drainage) and purulent drainage. The progress note further stated RN #259 obtained orders from Resident #81's hospital paperwork, changed Resident #81's dressing, and had placed the wound treatment orders in Resident #81's medical records. RN #259 contacted the nurse practitioner to inform of the malodorous and pale yellow tissue in the wound and had received orders to administer doxycycline (an antibiotic) 100 milligrams (mg) twice a day for seven days . Review of Resident #81's physician's orders in the electronic medical record revealed orders dated 05/26/25 to cleanse the wound to Resident #81's lumbar spine with vashe, apply aquacel AG advanced, and cover with a bordered dressing and for doxycycline 100 mg twice daily for 7 days for a lumbar spine wound. There was no evidence a culture had been ordered prior to initiating antibiotic therapy to determine if the ordered antibiotic was appropriate for Resident #81's infection. Review of a wound observation dated 05/28/25 authored by Licensed Practical Nurse (LPN) #280 revealed to irrigate Resident #81's lumbar wound with normal saline, apply a Dakins solution (an antiseptic used to clean and disinfect wounds and to help prevent and treat topical infections), and cover with a clean dry dressing daily and as needed. Further review of wound observation record revealed the wound measured 14 centimeters (cm) in length and 4.5 cm in width. The wound was open and noted to have sanguineous (bloody) drainage. The surgical wound was noted to have slough covering 90% of the wound bed. Review of a progress note dated 05/30/25 time 3:04 P.M. authored by RN #259 revealed she had entered Resident #81's room to administer afternoon medications and observed Resident #81 lethargic and unable to follow commands or answer questions without being re-directed several times. RN #259 contacted the nurse practitioner who gave orders to transfer Resident #81 to the emergency room for evaluation. The resident did not return to the facility after being transferred to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/24/25 at 11:45 A.M. with RN #259 revealed when she entered Resident #81's room to provide routine care on 05/26/25 she had observed a foul odor and began attempting to locate the source of the odor. RN #259 stated upon assessment, she observed a dressing to Resident #81's lumbar area that was dated 05/21/25 and was saturated with purulent drainage. RN #259 stated she had attempted to locate physician orders to perform the wound care and stated there were no orders in place at that time. RN #259 stated she located Resident #81's hospital admission paperwork dated 05/21/25 and performed the dressing change according to the hospital orders. RN #259 additionally stated she then placed the wound care orders in Resident #81's electronic medical record. RN #259 further stated Resident #81's lumbar wound appeared to be infected, and she contacted the facility's nurse practitioner who had ordered oral antibiotics. RN #259 stated after 05/26/25, she did not work for a few days and upon her return (on 05/30/25) she had noted Resident #81 appeared lethargic and was not responding to her normally. RN #259 stated she had contacted the nurse practitioner and had received orders to send Resident #81 to the hospital for evaluation. RN #259 stated she had discussed the issue with Resident #81's dressing change orders with Regional Registered Nurse (RRN) #304. Interview on 06/25/25 at 11:50 A.M. with LPN #280 revealed she was the facility's wound nurse. LPN #280 stated she had not been made aware Resident #81 had a wound until 05/28/25, and stated she had assessed and measured the area at that time. LPN #280 noted the presence of significant slough in the wound bed and implemented new treatment orders for Resident #81's lumbar surgical wound. LPN #280 denied being aware of any concerns regarding Resident #81 prior that 05/28/25. Interview on 06/25/25 at 12:35 P.M. with RRN #304 revealed she had reviewed Resident #81's progress note from 05/26/25 authored by RN #259 and stated she began an investigation. RRN #304 confirmed Resident #81's treatment order on her hospital discharge paperwork dated 05/21/25 was not transcribed and implemented until 05/26/25 (five days after admission), despite licensed staff documenting daily the resident's lumbar surgical site was clean and dry . RRN #304 stated she implemented corrective action that included re-education, wound care order and observation audits, and chart reviews for accurate and timely physician orders. Review of the facility policy titled Skin and Wound Care Guidelines revised 10/2015 revealed the admitting nurse would be responsible for obtaining the initial treatment orders. The cardinal rule for an open wound was to keep the exposed tissue moist and the surrounding intact skin dry. The dressing should be maintained as clean, dry and intact to all open wounds. If the dressing was saturated or the dressing is not dry and intact, the policy noted the dressing should be changed. The deficient practice was corrected on 05/28/25 when the facility implemented the following corrective actions: - On 05/26/25, Resident #81's physician was notified of the wound care transcription error and correct wound care orders were obtained and input into the resident's record. - On 05/26/25, the Director of Nursing (DON) performed a head-to-toe assessments on all residents with no negative findings. All areas of skin impairment had an appropriate physician's order for treatment. - On 05/26/25, the DON completed all residents' records for accuracy of transcribed orders for residents who were newly admitted to the facility between 05/21/25 and 05/26/25. There were no additional medication or treatment orders missing or inaccurately transcribed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- Between 05/26/25 and 05/28/25, the DON educated all nurses on accurate transcription of medication and treatment orders. Any new staff would be educated upon hire on the proper order transcription during the orientation process by the DON. - On 05/26/25, the DON or designee began ongoing chart audits of residents' medication and/or treatment orders. The audits consisted of reviewing new orders for accurate transcription five times weekly, for a duration of one month. The results of the audits would be reviewed in the facility's Quality Assurance Performance Improvement (QAPI) meetings. The audits were completed on 06/25/25. - On 05/26/25, the DON or designee began ongoing observational audits of wound care to ensure treatments were completed per physicians' order and utilizing appropriate technique on three residents, five times weekly, for a duration of one month. The results of the audits would be reviewed in the facility's QAPI meetings. The audits were completed on 06/25/25. - On 05/28/25, a QAPI meeting was held to discuss the incident with Resident #81's wound and the subsequent audits, facilitated by the Administrator. In attendance were the Administrator, DON, Medical Director, Social Worker #275, Maintenance Director #274, MDS Nurse #258, and Admissions Director #263. There were no additional concerns identified and no additional recommendations during the QAPI meeting. This deficiency represents non-compliance investigated under Complaint Number OH00166423.