STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 35031 Based on observation, staff interview and policy review, the facility failed to maintain personal health information in a confidential manner. This affected one (#22) of 40 residents who was randomly observed. The facility census was 40. Findings include: Observation on 06/01/22 at 3:22 P.M., revealed Licensed Practical Nurses (LPN) #110 and #111 were standing in the hallway just outside of Resident #22's room. LPN #111 held a cell phone while facetiming a physician and LPN #110 was discussing Resident #22's treatments and describing his wounds. Residents #26 and #38 were very near to the area and could overhear the conversation. Interview on 06/01/22 at 3:40 P.M., with LPN #111 provided verification of the lack of privacy afforded Resident #22 with the discussion with the doctor while in the hallway. Review of the undated policy titled HIPPA Confidentiality and Non-disclosure Agreement, revealed employees should refrain from communicating information about a resident in a manner that would allow others to overhear such information. This deficiency substantiates Complaint Number OH00131158.

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
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 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** 35031 Based on medical record review, policy review and staff interview, the facility failed to ensure medications were administered timely. This affected one (#29) of four reviewed for as needed medications. The facility census was 40. Findings include. Review of the medical record of Resident #29 revealed an admitted [DATE]. Diagnoses include diabetes mellitus type II with diabetic neuropathy, acquired absence of right leg below knee, hypertensive chronic kidney disease stage 3B, diabetic retinopathy without macular edema, acute embolism and thrombosis of left lower extremity, phantom limb syndrome with pain, anemia, generalized anxiety disorder, gastroesophageal reflux disease without esophagitis, and long-term use of insulin. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #29 was cognitively intact and required extensive assistance of one staff for bed mobility, toileting, and personal hygiene, and extensive assistance of two staff for transfers. The assessment revealed she was always continent of bowel and bladder. The assessment revealed she received schedule and as needed pain medications and she experienced pain frequently rated as eight out of 10. The assessment revealed Resident #29 was at a risk to develop pressure ulcers or injuries and had none currently. She had a pressure reliving device for the bed. The assessment revealed Resident #29 received insulin seven days of the period and one order change was noted. She further received an opioid and antidepressants seven days. Review of the medication administration record (MAR) dated 05/22 revealed Resident #29 received her 9:00 P.M. scheduled sennosides 8.6 milligrams (mg) (for constipation), Levemir insulin 20 units, and Juven Nutrivigor packet (for wound healing), the medications were scheduled for 05/03/22 and documented as administered on 05/04/22 at 1:22 A.M. by LPN #111. Review of the MAR revealed the 9:00 P.M., scheduled Amitriptyline 10 mg tablet (for neuropathy); Levemir 20 units; Juven Nutrivigor one packet; metformin 500 mg, give two tablets (for diabetes); sulfamethoxazole-Trimethoprim tablet 800-160 mg (for bacterial infection); sennosides 8.6 mg; and Gabapentin 100 mg (for neuropathy) were administered on 05/07/22 at 1:13 A.M. by LPN #112. The medications scheduled for 05/07/22 at 9:00 P.M., were administered on 05/08/22 at 1:03 A.M. by LPN #112. The medications scheduled for 05/16/22 at 9:00 P.M., were administered on 05/17/22 at 1:47 A.M. by LPN #112. The medications scheduled on 05/17/22 at 9:00 P.M., were administered on 05/18/22 at 2:14 A.M. by LPN #112. The medications scheduled on 05/22/22 at 9:00 P. M., were administered on 05/22/22 at 11:28 P.M. by LPN #112. Interview on 05/31/22 at 9:00 A.M., with Licensed Practical Nurse (LPN) #111 revealed she could not recall why the medications were administered late on 05/03/22 indicating another resident may have fallen and pulled her away from the medication pass. Interview on 05/31/22 at 3:00 P.M., with Director of Nursing provided verification of the late administrations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Medication Administration policy, revised 04/20/17, revealed under Procedure heading II Safety Precautions,stated to observe the five rights for medication administration. The right resident, right time, right medication, right dose, and right method of administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on medical record review, staff interview and policy review, the facility failed to ensure medications were administered without adequate indication for use and adequate monitoring after administration. This affected three residents (#29, #4 and #16) of four reviewed for as needed medications. The facility census was 40. Findings include. 1. Review of the medical record of Resident #29 revealed an admitted [DATE]. Diagnoses include diabetes mellitus type II with diabetic neuropathy, acquired absence of right leg below knee, hypertensive chronic kidney disease stage 3B, diabetic retinopathy without macular edema, acute embolism and thrombosis of left lower extremity, phantom limb syndrome with pain, anemia, generalized anxiety disorder, gastroesophageal reflux disease without esophagitis, and long-term use of insulin. Review of the controlled drug administration record labeled for Resident #29 for tramadol 50 milligrams (mg) revealed the following dates and times the medication was documented as having been pulled for administration but no corresponding documentation on the MAR or in the nurses' notes as having been administered to Resident #29: on 05/15/22 at 3:15 A.M., by Licensed Practical Nurse (LPN) #132; on 05/16/22 at 5:00 A.M., by LPN #132; on 05/17/22 at 1:00 A.M., by LPN #112; on 05/17/22 at 11:00 P.M., by LPN #112; on 05/18/22 at 6:00 P.M., by Registered Nurse (RN) #120; on 05/19/22 at 2:00 A.M., by LPN #132; on 05/20/22 at 3:00 A.M., by LPN #132; on 05/21/22 at 3:40 A.M., by LPN #112; on 05/21/22 at 8:00 P.M., by LPN #112; on 05/22/21 at 5:45 A.M., by LPN #112; on 05/23/22 at 12:30 A.M., by LPN #112; on 05/23/22 at 11:50 P.M., by LPN #132; on 05/24/22 at 2:00 A.M., by LPN #132; on 05/25/22 at 5:15 A.M., by LPN #132; on 05/26/22 at 11:00 A.M., by RN #120; on 05/26/22 at 6:30 P.M., by LPN #102; on 05/27/22 at 1:30 A.M., by LPN #112; on 05/28/22 at 3:30 A.M., by LPN #112; and on 05/28/22 at undocumented time by RN #175. Review of the May 2022 Medication Administration Record (MAR) revealed the Tramadols listed were not recorded as given. Review of the progress notes and resident assessments revealed there no documentation of the residents pain level or that Tramadol was given. Further review of the medical record revealed there was no documentation as to the effectiveness of the Tramadol. Interview on 05/31/22 at 11:07 A.M., with Director of Nursing (DON) and Regional Director of Clinical Operations #90 provided verification the medications were administered late as described above. They further verified the tramadol 50 mg tablets were documented as having been pulled yet not documented on the MAR as being administered, no documentation the reason for giving or the effectiveness. 2. Review of the medical record of Resident #4 revealed an admitted [DATE]. Diagnoses include, peripheral vascular disease, hypertension, low back pain , generalized anxiety, and unilateral primary osteoarthritis of left knee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Controlled Drug Administration Record for Resident #4 revealed tramadol 50 mg tablets were recorded as having been pulled for administration without documentation to indicate reason or efficacy for the following times: on 05/01/22 at 9:30 P.M., by LPN #132; on 05/04/22 at 10:00 P.M. by LPN #132; on 05/05/22 at 10:00 P.M. by LPN #132; on 05/06/22 at 9:00 P.M. by LPN #112; on 05/07/22 at 7:00 P.M. by RN #120; on 05/08/22 at 7:00 P.M. by RN #120; on 05/09/22 at 8:30 P.M. by LPN #132; on 05/13/22 at 8:00 P.M. by RN #120; on 05/16/22 at 8:00 P.M. by LPN #112; on 05/18/22 and 05/19/222 at 10:00 P.M. by LPN #132; on 05/20/22 at 7:45 P.M. by LPN #112; on 05/21/22 and on 05/22/22 at 8:00 P.M. by LPN #112; on 05/24/22 at 10:00 P.M. by LPN #132; on 05/25/22 and on 05/26/22 at 9:00 P.M. and on 05/27/22 at 10:00 P. M. by LPN #112 and 05/28/22 at 10:00 P.M. by LPN #132. Review of the May 2022 Medication Administration Record (MAR) revealed the Tramadols listed were not recorded as given. Review of the progress notes and resident assessments revealed there no documentation of the residents pain level or that Tramadol was given. Further review of the medical record revealed there was no documentation as to the effectiveness of the Tramadol. Interview on 05/31/22 at 11:07 A.M., with Director of Nursing (DON) and Regional Director of Clinical Operations #90 provided verification the medications were administered late as described above. They further verified the tramadol 50 mg tablets were documented as having been pulled yet not documented on the MAR as being administered, no documentation the reason for giving or the effectiveness. 3. Review of Resident #16s medical record revealed an admitted [DATE], with diagnoses including dementia, hypertension, osteoarthritis, peripheral vascular and benign prostrate hypertrophy. Review of quarterly Minimum Data Set (MDS) assessment , dated 03/16/22 revealed the resident's Brief Interview for Mental Status (BIMS) score was a two indicating severe cognitive impairment. He did not have a scheduled pain medication regimen. He complained of mild pain and hurting all over occasionally. Review of physician orders revealed an order for Tramadol (controlled substance to treat moderate to sever pain) 50 milligrams (mg.) every 8 hours as needed for moderate to severe pain. Review of plan of care dated 03/24/22 stated the resident is at risk for arthritis pain . Interventions include providing pain medication per the physician orders. Review of the Control Drug Administration Record for May 2022 revealed an order for Tramadol 50 mg one tablet every eight hours for moderate to severe pain. On 05/20/22 at 8:30 P.M., Licensed Practical Nurse (LPN) #112 signed the sheet stating one tablet was removed from the narcotic drawer. On 05/26/22 at 10:00 P.M., LPN #112 signed the Control Drug Administration Sheet stating one tablet of Tramadol was removed from the narcotic drawer. On 05/27/22 at 10:00 P.M., LPN #112 signed the Control Drug Administration Sheet stating one tablet of Tramadol was removed from the narcotic drawer. On 05/28/22 at 8:30 P.M., LPN #132 signed the Control Drug Administration Sheet stated one tablet of Tramadol was removed from the narcotic drawer. Review of the May 2022 Medication Administration Record (MAR) revealed the Tramadols listed were not recorded as given. Review of the progress notes and resident assessments revealed there no documentation of the residents pain level or that Tramadol was given. Further review of the medical record revealed there was no documentation as to the effectiveness of the Tramadol. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/01/22 at 4:04 P.M., with the Director of Nursing verified the narcotic Tramadol was taken from the narcotic drawer and not recorded on the MAR or in the progress notes as to the indication for administration of the narcotic or it's effectiveness. Review of the policy titled Medication Administration revised 04/20/17, stated under section VI Narcotic, stated narcotics are to be signed out on the narcotic substance form when the narcotic is removed, record narcotic in the MAR, provide the reason the medication was given and pain level before and after administration. This deficiency substantiates Complaint Number OH00131158

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 22654 Based on medication administration observation, medical record review, staff interview, manufacture's recommendations and policy review, the facility failed to ensure medications were administered with an error rate of less than 5%. A total of 25 opportunities were observed with three errors resulting in a 12% error rate. This affected three (#27, #37, and #22) of eight residents observed receiving medications. The facility census was 40. Findings include: Observation on 05/31/22 at 4:30 P.M., revealed Licensed Practical Nurse (LPN) #102 obtained a finger stick blood sugar of 195 for Resident #27. LPN #102 was observed administering Novolog Insulin one unit per Novolog Flex Pen. LPN #102 placed a clean needle on the Flex pen and dialed one unit with the selector. She administered the insulin in Resident #27 right upper abdomen. LPN #102 was observed not to prime the pen prior to administration. Review of the May 2022 physician's order revealed a sliding scale insulin order to give one unit of Novolog Insulin per Novolog Flex Pen for blood sugars between 140 -199. Interview on 05/31/22 at 4:40 LPN #102, verified she did not prime the needle stating you can only prime a Flex Pen once for the first dose administered from the cartridge . Review of the manufacture's instructions Instructions for Use Novolog FlexPen revealed under sections D- H stated before each injection turn the dose selector to 2 units. Hold the Novolog FlexPen upwards, tap the cartridge gently a few time to make sure any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push button all the way in until the dose selector returns to zero. Turn the selector to the number of units to be given. Observation on 05/31/22 at 5:05 P.M., revealed LPN #102 was administering medication to Resident #37. She gave him Colace (stool softener) and Metformin (medication to decrease elevated blood sugars). After Resident #37 took the medications he stated he usually gets three pills at 5:00 P.M. LPN #102 stated she could not find the third medication, Plavix (anticoagulant) 75 milligrams (mg.). She stated if the pharmacy came before 6:00 P.M., she would give him the Plavix and if the pharmacy did not come he would not be able to get the medication today. Review of Resident #37's May 2022 physician orders revealed an order for Plavix 75 mg to be given once a day in the afternoon. Review of Resident #37 's May 2022 Medication Administration (MAR) reveled the Plavix was marked as unavailable for 05/31/22 at 5:00 P.M. Interview on 05/31/22 at 8:32 P.M., with LPN #132 verified the Plavix for Resident #37 was marked as not given due to being unavailable. She stated she was not aware Resident #37 had not received Plavix today. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/31/22 at 8:35 P.M., with LPN #132 was preparing Resident #22 medication. She drew up 20 units of Lispro (fast acting) insulin. LPN # 132 stated Resident #22 blood sugar was 121 and he was to get 20 units of insulin at bedtime. She placed four oral medications in a mediation cup and entered Resident #22 room. Resident took the oral medications with water. LPN #132 administered the Lispro Insulin subcutaneously into his upper left arm. Upon leaving the room LPN # 132 was asked to identify the insulin she had given to Resident #22. She removed the bottle of Lispro and verified she had given Lispro (short acting insulin) 20 units. She verified the physician's order on the electronic MAR was for Lantus (long acting insulin) to be given. LPN #132 notified the physician immediately and orders were put in place to monitor the residents blood sugar for 6 hours and give glucose (Glucagon) for blood sugars under 60. Review of the May 2022 physician orders revealed an order for Lantus Insulin 20 units to be given at bedtime. Review of the policy titled Medication Administration policy, revised 04/20/17, revealed under Procedure heading II Safety Precautions,stated to observe the five rights for medication administration. The right resident, right time, right medication, right dose, and right method of administration. This deficiency substantiates Complaint Number OH00131158.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 22654 Based on medication administration observation, medical record review, staff interview, manufacture's recommendations and policy review, the facility failed to administer the correct medication as ordered by the physician. This affected two (#22 and #27) of eight residents observed for medication administration. The facility census was 40. Findings include: Observation on 05/31/22 at 4:30 P.M., revealed Licensed Practical Nurse (LPN) #102 obtained a finger stick blood sugar of 195 for Resident #27. LPN #102 was observed administering Novolog Insulin one unit per Novolog Flex Pen. LPN #102 placed a clean needle on the Flex pen and dialed one unit with the selector. She administered the insulin in Resident #27 right upper abdomen. LPN #102 was observed not to prime the pen prior to administration. Review of the May 2022 physician's order revealed a sliding scale insulin order to give one unit of Novolog Insulin per Novolog Flex Pen for blood sugars between 140 -199. Interview on 05/31/22 at 4:40 LPN #102, verified she did not prime the needle stating you can only prime a Flex Pen once for the first dose administered from the cartridge . Review of the manufacture's instructions Instructions for Use Novolog FlexPen revealed under sections D- H stated before each injection turn the dose selector to 2 units. Hold the Novolog FlexPen upwards, tap the cartridge gently a few time to make sure any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push button all the way in until the dose selector returns to zero. Turn the selector to the number of units to be given. Observation on 05/31/22 at 8:35 P.M., with LPN #132 was preparing Resident #22 medication. She drew up 20 units of Lispro (fast acting) insulin. LPN # 132 stated Resident #22 blood sugar was 121 and he was to get 20 units of insulin at bedtime. She placed four oral medications in a mediation cup and entered Resident #22 room. Resident took the oral medications with water. LPN #132 administered the Lispro Insulin subcutaneously into his upper left arm. Upon leaving the room LPN # 132 was asked to identify the insulin she had given to Resident #22. She removed the bottle of Lispro and verified she had given Lispro (short acting insulin) 20 units. She verified the physician's order on the electronic MAR was for Lantus (long acting insulin) to be given. LPN #132 notified the physician immediately and orders were put in place to monitor the residents blood sugar for 6 hours and give glucose (Glucagon) for blood sugars under 60. Review of the May 2022 physician orders revealed an order for Lantus Insulin 20 units to be given at bedtime. Review of the Medication Administration policy, revised 04/20/17, revealed under Procedure heading II Safety Precautions,stated to observe the five rights for medication administration. The right resident, right time, right medication, right dose, and right method of administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency substantiates Complaint Number OH00131158.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365809	A. Building B. Wing	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Lake Healthcare Center	1209 Indiana Avenue St Marys, OH 45885

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 22654 Based on observation, staff interview, and policy review, the facility failed to wear facial masks during direct resident contact. This had the potential to affect 40 of 40 residents residing in the facility. Findings include: Observation of staff working the 200 hallway between 4:00 P.M. to 5:15 P.M., revealed Licensed Practical Nurse, (LPN) #102 was administering medication to eight residents (#22,#23, #27, #29, #26, #28,#29, and #37) on the 200 hallway. LPN #102 was observed wearing a surgical mask below her nose just covering her lower lip. Personal Care Assistant (PCA) #421 and State tested Nursing Assistant (STNA) #411 were observed going in and out of resident's room passing and gathering trays with surgical masks on not covering their nose. On 05/31/22 at 5:20 PM during an interview the Director of Nursing verified the staff were to wear a surgical mask covering both their nose and mouth at all times in the building. She verified LPN #102 , PCA #421 and STNA #411 currently were wearing their surgical masks below their nose. She stated it is her expectation all staff will wear a mask that covers both their nose and mouth when caring for residents. Review of the policy titled Criteria for COVID-19 Requirements and Resident Placement, revised 03/02/22 , stated under General Care Areas and [NAME] Rooms , employees are to wear a surgical mask and eye protection when providing care for residents. This deficiency substantiates Complaint Number OH00131158.