| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365825 | A. Building<br>B. Wing | 08/22/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grande Oaks | 24579 Broadway Ave<br>Oakwood Village, OH 44146 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>39333<br><br>Based on observation and interview, the facility failed to maintain the environment in a clean and sanitary manner. This affected three Residents (#8, #4, and #53) and had the potential to affect the 58 residents residing in the facility.<br><br>Findings include:<br><br>Observations during the initial tour of the facility and screening of residents for the annual and complaint survey on 08/19/19 from 8:17 A.M. to 11:37 A.M. revealed the following:<br><br>The dining room had food debris and water on the floor. This was verified by Social Worker #81 at 8:17 A.M. on 08/19/19.<br><br>Resident #8's wall had dried liquid splatter on it, and the call light was not within reach and was crusted with dirt. This was verified at the time of observation by State tested Nursing Assistant (STNA) #39 on 08/19/19 at 10:06 A.M.<br><br>There were used gloves rolled up into a ball with a syringe (no needle) on the floor of Resident #4's room. This was verified on 08/19/19 at 10:17 A.M. by Medical Records Coordinator #41.<br><br>Resident #53's air conditioner did not fit the window properly leaving gaps to the outside. This was verified on 08/19/19 at 11:37 A.M. by Licensed Practical Nurse (LPN) #46.<br><br>Interview on 08/21/19 at 1:35 P.M. with the Director of Maintenance #20 revealed Resident #53's air conditioning unit was replaced recently, and items were ordered to make it more aesthetic looking. The sky light in the dining room was leaking. There was a contractor out to look at it since the roof was repaired a year ago from what he was told.<br><br>Interview on 08/21/19 at 11:24 A.M. with Dietary Manager #103 revealed that housekeeping was responsible for the cleaning of the dining room floor.<br><br>Interview on 08/21/19 at 4:46 P.M. with Director of Housekeeping #1 revealed that housekeeping staff worked 7:00 A.M. to 3:00 P.M. and cleaned rooms daily. They were responsible for the dining room floor after breakfast and lunch, but dietary staff was responsible for the dining room floor after dinner.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of housekeeping aide duties revealed common areas should be cleaned. There were no policies stating how to clean common areas.<br><br>This deficiency substantiates Complaint Number OH00106257. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>39333<br><br>Based on interview and review of the staffing punch detail reports, the facility failed to ensure a registered nurse (RN) was on-site 8 consecutive hours a day two days (08/17/19 and 08/18/19) of seven days reviewed for staffing. This had the potential to affect all 58 residents residing in the facility.<br><br>Findings included:<br><br>Review of the punch detail reports for 08/12/19 to 08/18/19 revealed there was no RN coverage on 08/17/19 and 08/18/19.<br><br>On 08/22/19 at 1:33 P.M. interview with Scheduler #44 verified that there was no RN scheduled for 08/17/19 and 08/18/19 but stated the Director of Nursing (DON) was in the building. No documented evidence was produced to reflect the DON was onsite for eight consecutive hours on 08/17/19 and 08/18/19. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333<br><br>Based on record review and staff interview, the facility failed to ensure prescribed as needed (PRN) psychotropic medications for Resident #42 were not discontinued or renewed after the initial fourteen-day period. This affected one resident (Resident #42) of five residents (Residents #22, #29, #31, #39 and #42) reviewed for unnecessary medication use. The facility census was 58.<br><br>Findings include:<br><br>Record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, major depressive disorder, pseudobulbar affect and Alzheimer's disease.<br><br>Review of the physician's order revealed on 06/24/19 he was prescribed Ativan (Lorazepam), an anti-anxiety medication, 0.5 milligrams daily PRN. There was no rationale provided by the attending physician to continue the medication beyond the initial 14 days.<br><br>A review of the pharmacy recommendation dated 07/10/19 for Resident #42 revealed the resident had an order dated 06/24/19 for a PRN psychoactive medication, Ativan (Lorazepam), that was used twice. Under new regulations effective 11/28/17, PRN orders for psychoactive medications are limited to fourteen days. The attending physician may extend the order beyond the fourteen days by providing rationale and duration. There was no documented follow-up to this recommendation.<br><br>An interview on 08/22/19 at 1:33 P.M. with Director of Nursing revealed she was new to the facility and could not find the pharmacist recommendation with the doctor's response. She said, everybody should know about the 14-day rule. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>35768<br><br>Based on observation and staff interview, the facility failed to administer all of the crushed mediations during medication pass resulting in a 35 percent medication error rate prior to surveyor intervention. This affected one (Resident #17) of one resident who received medications via a percutaneous endoscopic gastrostomy (PEG) tube (a tube located in the stomach to receive nutrition and medications). The facility census was 58.<br><br>Findings Include:<br><br>Observations on 08/20/19 at 8:19 A.M., Licensed Practical Nurse (LPN) #63 crushed nine medications, Pepcid 20 milligrams (mg) (antacid), Acidophilus (probiotic), Claritin 10 mg (antihistamine), Magnesium 400 mg (supplement), Senna 8.6 mg (laxative), Miralax 17 grams (laxative), Vitamin B1 (supplement), Vimpat 100 mg (anticonvulsant), and divided them into two cups. LPN #63 poured water into the cups to dilute the medications before administering the medications through Resident #17's PEG tube. LPN #63 completed the medication pass, stacked the cups together and walked toward the door. The cups had an estimated one sixteenth of a teaspoon of medication remaining in both cups.<br><br>LPN #63, when questioned about the remaining medications, verified there were medications remaining in the cups and stated she would add water if requested to do so by the surveyor. LPN #63 stated she usually stirred the medication with a spoon, but she did not do that this time. LPN #63 added more water and completed the medication administration to Resident #17.<br><br>Observations on 08/19/19 and 08/20/19 of medication administration revealed 26 medications with nine errors resulting in a 35 percent medication error rate prior to surveyor intervention. |