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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365331	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelby Pointe, Inc	100 Rogers Lane Shelby, OH 44875

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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 44454 Based on observation and staff interview, the facility failed to ensure all required postings were displayed in the facility in a manner which was accessible at all times. This affected all 44 residents residing in the facility. The facility census was 43. Findings include: Observation on 01/02/25 at 1:22 P.M., of all facility common areas and hallways revealed there was no posted contact information for pertinent state agencies and advocacy groups, such as the State Survey agency, the State licensure office, adult protective services, the protection and advocacy network, home and community-based service programs, and the Medicaid Fraud Control Unit. An interview with the Administrator on 01/02/25 at approximately 1:23 P.M. verified there was no list of pertinent state agencies and advocacy groups posted.

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review and staff interview, the facility failed to ensure resident Preadmission Screening and Resident Review (PASRR) status was correctly coded on the Minimum Data Set (MDS) assessment. This affected eight (#1, #11, #16, #18, #25, #30, #36, and #41) of 43 residents reviewed for MDS assessment accuracy. The facility census was 43. Findings Include: 1. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, type two diabetes, and epilepsy. Review of the PASRR level two evaluation from the state PASRR agency dated 10/24/23 revealed Resident #1 was ruled out from further review indicting Resident #1 did not have a serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or related condition. Review of section A of Resident #1's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, Yes, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The facility subsequently answered, Yes, to the area of, Level II PASRR conditions: Serious Mental Illness, for Resident #1. 2. Record review revealed Resident #11 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, paranoid schizophrenia, and epilepsy. Review of the PASRR level two evaluation from the state PASRR agency dated 11/09/23 revealed Resident #11 had a level two mental illness. Review of section A of Resident #11's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 3. Record review revealed Resident #16 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, schizophrenia, and mood disorder. Review of the PASRR level two evaluation from the state PASRR agency dated 09/01/23 revealed Resident #16 had a level two mental illness. Review of section A of Resident #16's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 4. Record review revealed Resident #18 was admitted to the facility on [DATE] with diagnoses that included dementia, type two diabetes, and mood disorder. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the PASRR level two evaluation from the state PASRR agency dated 10/02/24 revealed Resident #18 was ruled out from further review, indicating Resident #18 did not have a SMI, ID, DD, or related condition. Review of section A of Resident #18's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, Yes, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The facility subsequently answered, Yes, to the area of, Level II PASRR conditions: Serious Mental Illness, for Resident #18. 5. Record review revealed Resident #25 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, major depressive disorder, anxiety disorder, and other sexual disorder. Review of the PASRR level two evaluation from the state PASRR agency dated 11/13/23 revealed Resident #25 had a level two mental illness. Review of section A of Resident #25's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 6. Record review revealed Resident #30 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, major depressive disorder, and anxiety disorder. Review of the PASRR level two evaluation from the state PASRR agency dated 10/26/23 revealed Resident #30 had a level two mental illness. Review of section A of Resident #30's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 7. Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, major depressive disorder, anxiety disorder, and other sexual disorder. Review of the PASRR level two evaluation from the state PASRR agency dated 11/04/24 revealed Resident #36 had a level two mental illness. Review of section A of Resident #36's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	8. Record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses that included dementia with psychotic disturbance, major depressive disorder, and schizoaffective disorder. Review of the PASRR level two evaluation from the state PASRR agency dated 11/27/24 revealed Resident #41 had a level two mental illness. Review of section A of Resident #41's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Interview with Social Service Designee (SSD) #152 on 12/31/24 at 1:15 P.M. verified the PASRR status for Resident #1, Resident #11, Resident #16, Resident #18, Resident #25, Resident #30, Resident #36, and Resident #41 were coded incorrectly on the MDS assessments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, staff interview, medical record review, review of investigations, and review of a facility policy, the facility failed to ensure fall interventions were in place as ordered and care planned, failed to ensure falls were properly investigated, and failed to ensure interventions to prevent future falls were appropriate to the nature of the incident. This affected one (#8) of two residents reviewed for falls. The facility census was 43. Findings include: Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, moderate protein-calorie malnutrition, chronic respiratory failure, major depressive disorder, other generalized epilepsy, cachexia, generalized anxiety disorder, bipolar disorder, and depression. Review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and had two or more falls since admission. Review of the physician order dated 03/28/24 revealed an order for non-skid strips in front of the toilet. Review of Resident #8's plan of care dated 04/10/24 revealed the resident was at risk for falls characterized by history of falls and injury, pain, use of psychotropic medications, unsteady gait, weakness, and ambulating without assistance. Interventions included keeping the bed in the lowest position, colored tape to wheelchair breaks, encouraging to be up by he nurses station, encouraging to toilet after smoke break, a fall mat to the bedside, personal alarm to the chair, visual reminder in bathroom and room to remind to call for assistance, removing the wheelchair from room while in bed (initiated 07/22/24 and revised 10/08/24), and educating the staff on proper placement of wheelchair when in bed (initiated 09/10/24 and revised 10/08/24). Review of Resident #8's progress note dated 07/21/24 revealed she was found laying on her stomach in her room. She reported she was getting out of bed and tripped over her wheelchair. A visual reminder to use the call light for assistance was implemented. Review of Resident #8's fall investigation dated 07/21/24 revealed the resident fell while getting out of bed when she tripped over her wheelchair. Additional interventions included educating to use call light for assistance and removing the wheelchair from the room when the resident was in bed. Review of Resident #8's progress note dated 08/03/24 revealed the nurse was notified the resident had fallen. She was on the floor between her bed and wheelchair. She stated she was transferring and fell to the floor as the resident reported she wanted to go to the bathroom. The intervention was to reeducate staff on removing the resident's wheelchair from the room while she was in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's progress note dated 08/31/24 revealed the resident remained on neurological checks that were initiated at 3:15 A.M. from the previous shift. She had no apparent injuries and range of motion was within normal limits. There was no further documentation related to this incident. Review of Resident #8's progress note and fall investigation dated 11/22/24 revealed the resident was found on the floor in the bathroom as she was going into the bathroom in her wheelchair. She reported she tried to go to the bathroom by herself and hit the back of her head. The intervention implemented was to maintain a low bed at all times. Observation on 12/30/24 at 1:55 P.M. and 3:41 P.M. revealed Resident #8 in bed with her wheelchair next to the bed. Further observation at 3:41 P.M. revealed there were no non-skid strips in front of the toilet and no signs in the bathroom or room reminding the resident to ask for assistance. Interview on 12/30/24 at 3:41 P.M. with Licensed Practical Nurse (LPN) #110 verified the wheelchair was next to Resident #8's bed, and verified there were no non-skid strips in front of the toilet or signs in the bathroom or room to remind the resident to ask for assistance. She reported she was unsure if the resident put herself in the bed or not, but verified staff were to remove the wheelchair. Interview on 12/31/24 at 1:31 P.M. with the Director of Nursing (DON) verified the wheelchair was not removed from the room while the resident was in bed at the time of Resident #8's fall on 08/03/24. The DON additionally verified there was a fall on 08/31/24 and there was no documentation or investigation for the incident. The DON additionally verified a low bed was an inappropriate intervention for Resident #8's fall on 11/22/24 which took place in the bathroom. Review of the undated policy titled, Managing falls and fall risk, revealed the staff were to implement a resident-centered fall prevention plan to reduce the specific risk factor of falls for each resident.

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F 0758 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review and staff interview, the facility failed to adequately monitor a resident's targeted behaviors as ordered. This affected one (#3) of two residents reviewed for mood and behavior. The facility census was 43. Findings include: Review of Resident #3's medical record revealed an admitted [DATE] and diagnoses including cerebral palsy, major depressive disorder, moderate protein-calorie malnutrition, type two diabetes mellitus, anxiety, dysphagia, unspecified mood disorder, and metabolic encephalopathy. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition. Review of Resident #3's physician order dated 08/09/24 revealed an order to monitor daily behaviors. Review of Resident #3's plan of care dated 08/23/24 revealed the resident required the use of psychotropic medications with potential for adverse reactions related to adjustment disorder with depressed mood, anxiety, decline in health status, decline in mood and behavior, depression, impaired coping skills, and schizoaffective disorder. Interventions included offering non-pharmacological interventions to manage anxiety, giving medications as ordered, evaluating effectiveness and side effects of medications, and monitoring resident mood and behavior every shift and document on any behaviors. Review of Resident #3's physician order dated 08/27/24 revealed an order for Vistaril 50 milligrams (mg) one capsule two times a day for anxiety. Review of Resident #3's physician order dated 10/15/24 revealed an order for Depakene oral solution 250 mg two times a day for mood affective disorder and 500 mg at bedtime for adjustment disorder with depressed mood. Review of Resident #3's physician order dated 11/05/24 revealed an order for lorazepam 0.5 mg one tablet three times a day for anxiety. Review of Resident #3's physician order dated 12/11/24 revealed an order for Zoloft 50 mg one tablet in the morning related to adjustment disorder with depressed mood. Review of Resident #3's physician order dated 12/11/24 revealed an order for Zoloft 100 mg one time a day for depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's December 2024 medication administration record (MAR) between 12/03/24 to 12/30/24 revealed behaviors were present on 12/04/24, 12/05/24, 12/09/24, 12/10/24, 12/13/24, 12/14/24, 12/15/24, 12/18/24, 12/19/24, 12/23/24, 12/24/24, 12/25/24, 12/26/24, and 12/29/24; however, there was no indication what the actual behaviors were. Review of Resident #3's progress notes from 12/03/24 to 12/29/24 revealed there was no indication of what behaviors occurred on 12/04/24, 12/05/24, 12/09/24, 12/13/24, 12/14/24, 12/18/24, 12/19/24, 12/23/24, 12/24/24, 12/25/24, and 12/26/24. Interview on 01/02/25 at 11:00 A.M. with the Director of Nursing (DON) verified when Resident #3 displayed behaviors the nursing staff was supposed to be describing the behaviors that occurred and verified there was no documentation to support what the resident's behaviors were on the specified dates in December 2024.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 38091 Based on review of the facility assessment document and staff interview, the facility failed to ensure its facility assessment contained all required information. This had the potential to affect all 43 residents. The facility census was 43. Findings Include: Review of the current facility assessment document revealed the assessment did not contain specific staffing needs for each shift, such as day, evening, night and shifts. The assessment also did not contain information on how the facility would develop and maintain a plan to maximize recruitment and retention of direct care staff. Interview with the Administrator on 12/31/24 at 8:15 A.M. verified the assessment did not contain all required information.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review and staff interview, the facility failed to ensure a resident met established criteria for use of an antibiotic medication prior to administration. This affected one (#8) of one residents reviewed for urinary tract infections (UTIs). The facility census was 43. Findings include: Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, moderate protein-calorie malnutrition, chronic respiratory failure, major depressive disorder, other generalized epilepsy, cachexia, generalized anxiety disorder, bipolar disorder, and depression. Review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #8's urinalysis collected on 12/10/24, and with results obtained on 12/11/24, revealed the urine was abnormal in color and clarity, with urobilinogen, nitrite, leukocyte esterase, bacteria, and calcium oxalate crystals noted. Review of Resident #8's progress note dated 12/11/24 revealed there was a new order for the antibiotic Macrobid 100 milligrams (mg) twice a day for five days pending a culture and sensitivity. Review of Resident #8's physician order dated 12/11/24 to 12/11/24 revealed an order for Macrobid 100 mg by mouth twice a day for UTI for 10 administrations pending a culture and sensitivity. Review of Resident #8's physician order dated 12/11/24 to 12/14/24 revealed an order for Macrobid 100 mg one time only for UTI pending culture and sensitivity and give 100 mg by mouth two times a day for nine administrations. Review of Resident #8's document titled, Revised McGeer Criteria for Infection Surveillance Checklist, dated 12/12/24, revealed the UTI criteria were not met. Further review of the document revealed without a catheter residents had two meet two criteria for treatment symptoms and a microbiologic criteria and Resident #8 did not meet the criteria. Review of Resident #8's physician order dated 12/12/24 to 12/13/24 revealed an order for Macrobid 100 mg one time only upon returning from procedure. Review of Resident #8's nurse practitioner note dated 12/14/24 revealed the resident's culture and sensitivity was positive for Escherichia coli (E. coli) and extended-spectrum beta-lactamase (ESBL) with minimal sensitivities. She was treated with Macrobid pending the culture and the culture and sensitivity indicated other medications were appropriate. The Macrobid was to be discontinued. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's plan of care dated 12/24/24 revealed the potential for urinary tract infections related to poor toileting habits, history of UTIs, and reoccurring UTIs. Interventions included administering antibiotics as ordered, assessing urinary status, providing fluids throughout the day, and monitoring for signs of infection. Review of Resident #8's medication administration record (MAR) for December 2024 revealed Macrobid was administered twice on 12/11/24, 12/12/24, and 12/13/24. Review of Resident #8's medical record revealed no indication the physician or nurse practitioner was informed that Resident #8 did not meet the criteria for antibiotics. Interview on 12/31/24 at 2:32 P.M. with the Director of Nursing (DON) verified facility's criteria had not been met for an antibiotic related to Resident #8's UTI.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. 38091 Based observation and staff interview, the facility failed to maintain total visual privacy for residents. This affected two (#33 and #39) of 38 residents residing in semi-private rooms in the facility. The census was 43. Findings include: 1. Observation of resident rooms on 12/31/24 between 12:55 P.M. and 2:25 P.M. with the Administrator revealed there was no privacy curtain around Resident #39's bed to ensure total visual privacy. Further observation revealed Resident #39 shared the room with Resident #11. 2. Observation of resident rooms on 12/31/24 between 12:55 P.M. and 2:25 P.M. with the Administrator revealed there was no privacy curtain around Resident #33's bed to ensure total visual privacy. Further observation revealed Resident #33 shared the room with Resident #23. Interview on 12/31/24 at approximately 2:25 P.M. with the Administrator verified Resident #33 and Resident #39's beds did not have curtains around them to ensure total visual privacy.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49793 Based observation and staff interview the facility failed to maintain a clean and sanitary environment. This had the potential to affect all 43 residents residing in the facility. The census was 43. Findings include: An environmental tour was conducted on 12/31/24 between 12:55 P.M. and 2:25 P.M. with the Administrator. Observation of the exterior of the facility revealed the second window from the furthest east point of the building on the north side of the East Hall revealed the window screen was off its track and laying propped up against the building in an unsecured manner. Observation of the interior of the facility revealed the light ballast cover on the East Hall right before the egress exit revealed it contained dirt, debris, various dead bugs, and was partially cracked. Continued observation of Resident #23 and Resident #33's bedroom revealed missing molding around the boarders of the wall air conditioning and heating unit with deteriorating and eroding sheetrock from the edges and also gaps between the interior wall and exterior wall. Observation of Resident #25 and Resident #31's bedroom revealed significant gouges, indentations, and missing sheetrock behind Resident #31's headboard, and there was missing molding around the boarders of the wall air conditioning and heating unit deteriorating and eroding sheetrock from the edges and also gaps between the interior wall and exterior wall. Interview with the Administration on 12/31/24 between 12:55 P.M. and 2:25 P.M. verified all of the above environmental findings.