

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                                                 |
| <p>F 0804</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Many</p>                | <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, medical record review, resident and staff interview, review of a menu, and facility policy review, the facility failed to ensure food was palatable and served at acceptable temperatures. This affected directly affected (#61 and #88) of two residents reviewed for food concerns and had the potential to affect all residents receiving meals from the kitchen. The facility indicated there were three (#44, #66, and #102) residents who received nothing by mouth. The facility census was 92. Findings include: 1. Review of the medical record for Resident #61 revealed an admission date of 12/11/25. Diagnoses included but were not limited to hypokalemia, ulcerative colitis, and gastro-esophageal reflux disease. Review of the 12/18/25 admission Minimum Data Set (MDS) assessment for Resident #61 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident had intact cognition. Resident #61 was noted to require set up for meals and receive a regular diet. Review of the physician orders for Resident #61 revealed an order dated 12/13/25 for a regular diet. Interview on 01/06/26 at 3:21 P.M. with Resident #61 revealed she felt there were not a lot of alternate choices for meals and she did not always receive what she orders. Resident #61 stated she told staff she was tired of the alternate menu items, but was not offered any other additional options. Interview on 01/07/26 at 2:55 P.M. with Resident #61 revealed the pork chop she received was tough and dry and stated she could not eat it. Resident #61 stated it was not very warm; she was unable to cut it up, and tried to eat it with her hands, but stated it was tough and chose not to eat it. 2. Review of the medical record for Resident #88 revealed an admission date of 06/08/24. Diagnoses included but were not limited to cerebral palsy, morbid obesity, Parkinson's disease, and schizoaffective disorder bipolar type. Review of the 10/04/25 quarterly MDS assessment for Resident #88 revealed a BIMS score of 15 which indicated the resident had intact cognition. Resident #88 was noted to be independent for eating and receive a regular diet. Review of the physician orders for Resident #88 revealed an order dated 07/04/24 for a regular diet with large portions. Interview on 01/06/26 at 10:11 A.M. with Resident #88 revealed he felt the facility needed better food and felt it was low quality and deserved better options. Review of the facility menu for the week one, day four (Wednesday) lunch meal revealed baked pork chop, collard greens, black-eyed peas, cornbread, and whipped Jello parfait were on the menu. Observation of meal tray line temperatures on 01/07/26 at 11:50 A.M. with [NAME] #756 revealed the pork chop was 173 degrees Fahrenheit (F), black-eyed peas were 173 degrees F, collard greens were 179 degrees F, pureed pork was 173 degrees F, pureed greens were 179 degrees F, pureed black-eyed peas were 178 degrees F, mechanical soft pork was 166 degrees F, mashed potatoes were 180 degrees F, and chicken noodle soup was 200 degrees F. Observation revealed meal tray line started on 01/07/26 at 12:00 P.M. Meal tray line finished serving in the kitchen at 12:45 P.M. with the last cart going to the 800 unit (Chestnut unit). At 1:00 P.M., staff indicated the last tray had been passed on the 800 unit. A test tray was completed on 01/07/26 with Dietary Manager #796 at 1:02 P.M. on the Chestnut unit and the following temperatures were observed using Dietary Manager #796's thermometer: pork was 122.5 degrees F, black-eyed peas were 120 degrees F, and collard greens were 111.7 degrees F. Interview directly following the tasting of the meal test tray with Dietary Manager #796 taking temperatures revealed the items were not as warm as she would prefer and confirmed she probably would have heated the (continued on next page)</p> |                                                                                            |                                                 |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                            |                                                 |
| F 0804<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | items in the microwave before eating them. Interview on 01/08/26 at 10:40 A.M. with Registered Dietitian (RD) #995 revealed she has spoken to corporate about expanding the options on the alternate menu and felt they were somewhat limited for residents to choose from. RD #995 stated she used to do a meal test tray but was unsure how long it had been and stated it was at least six months. Review of the facility policy titled, Food and Nutrition Services, revised October 2017, revealed each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                            |                                                 |
| <p>F 0803</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, medical record review, staff interview, review of facility menus, review of facility production sheets, review of food substitution logs, and review of facility policies, the facility failed to ensure all menu items were provided for all residents, specifically residents with an order for a pureed diet. This directly affected one (#41) of four residents reviewed for food and nutrition with potential to affect seven (#9, #16, #55, #59, #68, #81, and #100) additional residents who received a pureed diet. The facility census was 92. Findings include: Review of the medical record for Resident #41 revealed an admission date of 09/05/24. Diagnoses included but were not limited to polyneuropathy, hyperlipidemia, noninfective gastroenteritis and colitis, and sarcoidosis. Review of the 11/14/25 significant change Minimum Data Set (MDS) assessment for Resident #41 revealed a Brief Interview of Mental Status (BIMS) score of four which indicated the resident had severe cognitive impairment. Review of activities of daily living (ADLs) for Resident #41 revealed she required supervision for eating and was also noted to receive a mechanically altered diet. Review of the 11/07/25 diet order for Resident #41 revealed she was on a regular pureed diet with nectar thickened liquids. Review of the facility menu for the week one, day four (Wednesday) lunch revealed food items included baked pork chop, collard greens, black-eyed peas, cornbread, and whipped Jello parfait. Review of the menu production sheet for the above listed meal, for puree textured meals, revealed residents with a pureed diet were to receive a #10 scoop (three and a quarter ounces) of pureed pork with two ounces of gravy on top, a #8 serving (four ounces) of collard greens, a #8 serving of refried beans, a #16 scoop of pureed cornbread, and six ounces of pureed Jello with whipped topping. Observation on 01/07/26 at 11:50 A.M. of kitchen tray line temperatures with [NAME] #756 revealed all temperatures were within appropriate range and appropriate scoop sizes were used. Observation on 01/07/26 at 12:08 P.M. revealed Resident #41's meal tray at the end of the tray line about to be put in the delivery cart. Resident #41's tray had pureed pork, pureed collard greens, pureed black-eyed peas, and pureed peaches. There was no evidence of pureed cornbread. Interview at the time of observation with [NAME] #756 confirmed the tray was complete and there was no pureed cornbread as listed on the production sheet. [NAME] #756 confirmed she had forgotten to make the pureed cornbread for the pureed residents. Interview on 01/07/26 at 1:02 P.M. with Dietary Manager #796 confirmed the production sheet for the menu listed pureed cornbread and also listed pureed Jello with whipped topping for the dessert. Dietary Manager #796 confirmed pureed Jello with whipped topping was on the menu and they had used pureed peaches for dessert because pureed Jello does not puree well and hold form. Dietary Manager #796 stated she had not completed a substitution log for the change and did not realize she needed to record the change on the menu or a log. Dietary Manager #796 confirmed residents should receive all approved menu items with their meals. Interview on 01/08/26 at 10:40 A.M. with Registered Dietitian (RD) #995 confirmed she reviews the seasonal menus twice a year prior to being initiated. RD #995 stated staff are to follow the menu and provide each listed item per their physician ordered diet. RD #995 confirmed the Dietary Manager was supposed to send her a log of food substitutions for her approve. Review of the facility menu substitution log for January through December 2025 revealed four listed substitutions. Review of January 2026's substitution log revealed one substitution for 01/07/26 following surveyor questioning and intervention. Review of the revised October 2017 facility policy titled, Menus, revealed menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences). Review of the April 2007 revised facility policy titled, Substitutions, revealed the food services manager, in conjunction with the Clinical Dietitian, may make food substitutions as appropriate or necessary. The Food Services Shift (continued on next page)</p> |                                                                                            |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                            |                                                                                            |                                                 |
| F 0803<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | Supervisor on duty will only make substitutions only when unavoidable. The Food Services Manager will maintain an exchange list identifying the seven exchanges of food groups. When in doubt about an appropriate substitution, the Food Services Manger will consult with the dietitian prior to making the substitution. All substitutions are noted on the menu and filed in accordance with established dietary policies. Notations of substitutions must include the reason for substitutions. |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            |                                                 |
| <p>F 0578</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on resident record review, resident interview, staff interview, and facility policy review, the facility failed to ensure residents advance directives were accurately documented in the resident medical record. This affected one (#88) of one resident reviewed for advanced directives. The facility census was 92. Findings include: Review of the electronic medical record (EMR) for Resident #88 revealed he was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, dysarthria and anarthria, and ataxia. Review of the EMR revealed Resident #88 was a full code status (cardiopulmonary resuscitation (CPR) would be initiated in an event of cardiac or respiratory arrest). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Review of the MDS assessment revealed Resident #88 required some assistance for activities of daily living (ADLs). Review of the care plan dated [DATE] revealed an advanced directive, revised [DATE], of full code status and to effectively communicate wishes by placing in the medical chart and/or when a resident must be transferred outside of the facility. Review of Resident #88's paper medical chart revealed a Do Not Resuscitate (DNR) form dated [DATE] that indicated Resident #88 elected to have a DNR Comfort Care (DNRCC) code status protocol to be implemented, meaning only comfort measures would be initiated in the event of a medical emergency. Interview on [DATE] at 11:34 A.M. with Licensed Practical Nurse (LPN) #786 revealed she was familiar with Resident #88 and was currently his nurse. During interview, a review of Resident #88 paper medical chart revealed a DNRCC code status and the EMR revealed a full code status. LPN #786 confirmed and verified Resident #88's advanced directives did not match and at that time changed the EMR advanced directives to match the paper medical chart. LPN #786 updated Resident #88's advanced directives without verification of code status, without consulting with Resident #88 and/or his Power of Attorney of Care (POAC). LPN #786 confirmed and verified the updated change to Resident #88's advanced directives. Review of the physician note dated [DATE] at 11:38 P.M., located in the EMR, revealed Resident #88 had an advanced directive of full code, discontinued. Review of the physician note dated [DATE] at 11:38 P.M. revealed Resident #88 had an advanced directive of DNRCC documented in the EMR. Interview on [DATE] at 11:45 A.M. with Resident #88 revealed he wanted to be a full code status and wanted the facility staff to perform CPR, but did not want to be put on a medical machine to keep him alive. Resident #88 revealed no staff spoke to him or approached him about his advanced directives. Review of the physician note dated [DATE] at 12:00 P.M., located in the EMR, revealed Resident #88 had an advanced directive of full code status. Review of the physician order revealed LPN #786 updated Resident #88's advance directives. Interview on [DATE] at 12:30 P.M. with Corporate Director of Nursing (CDON) #900 verified and confirmed the above information. Review of the facility document titled, Advanced Directives, revised [DATE], revealed the facility had a policy in place that revealed a resident advanced directive and/or changes would be documented in the care plan, medical record and obtained and maintained in the same section of the medical record and readily retrievable by the facility staff.</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                            |                                                 |
| <p>F 0645</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, staff interview, and policy review, the facility failed to ensure a resident's Preadmission Screening and Resident Review (PASRR) accurately reflected current mental health conditions. This affected one (#8) of three residents reviewed for PASRR. The facility census was 92. Findings include: Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, post-traumatic stress disorder (PTSD), and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact and required assistance of one staff person for completing her activities of daily living. Review of the Preadmission Screening and Resident Review (PASRR) document dated 01/19/24, under section E titled, Indications of Serious Mental Illness, revealed the facility did not provide/document indications that the resident had a diagnosis of post-traumatic stress disorder. Social Service Director (SSD) #701 verified Resident #8's PASRR did not address Resident #8's PTSD diagnoses in an interview on 01/07/25 at 2:00 P.M. Review of the undated policy titled, admission Criteria PASARR_OH, revealed the facility must follow federal and state regulations for the PASRR process.</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                                                 |
| F 0656<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to develop and implement a comprehensive, person-centered care plan to address a resident's healthcare needs. This affected one (#8) of one residents reviewed for post-traumatic stress disorder. The facility census was 92. Findings include: Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, post-traumatic stress disorder (PTSD), and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact and required assistance of one staff person for completing her activities of daily living. Review of the current comprehensive care plan for Resident #8 revealed no problems, goals, or interventions related to Resident #8's PTSD. Social Service Director (SSD) #701 verified in an interview on 01/08/26 at 8:45 A.M. that Resident #8's care plan did not address Resident #8's PTSD diagnoses in an interview on 01/07/25 at 2:00 P.M. SSD #701 further stated Resident #8 suffered from PTSD related to a gun fight between Resident #8 and her best friend. Review of the policy titled, Care Plans, Comprehensive Person Centered, dated 03/01/22, revealed the comprehensive person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                                                 |
| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, medical record review, hospital document review, review of fall investigations, resident representative interview, staff interview, and policy review, the facility failed to ensure resident care plans were revised to reflect residents' current medical and psychological status and resident representatives were provided the option to chose care and treatment interventions during care plan development. This affected two (#22 and #82) of twenty-two sampled residents. The facility census was 92. Findings include: 1. Review of Resident #22's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type; dementia with psychotic disturbance; and cognitive communication deficit.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact, required hands-on assistance for activities of daily living, and had no documented behaviors.</p> <p>Review of Resident #22's care plan dated 07/05/24 revealed the resident had behavior problems as evidenced by: traveling to vending machines and purchasing items regardless of diet; smearing feces in his room and throughout the facility; preferring to wear women's clothing and have nails painted; refusing to allow staff to organize personal items; hanging soiled clothing on heaters, in the shower, and over his wheelchair; refusing housekeeping services; embellishing stories about money and credit cards; and stating he carries ten credit cards at all times.</p> <p>Review of Resident #22's January 2026 physician orders revealed an order dated 06/10/24 to monitor behaviors every shift.</p> <p>Review of Resident #22's medication administration record (MAR) revealed Resident #22 had zero documented behaviors during November and December 2025 and January 2026.</p> <p>Despite the absence of any documented behaviors for at least three months, Resident #22's care plan continued to list extensive behavioral concerns without revision or reassessment.</p> <p>Social Service Director (SSD) #701 confirmed during an interview on 01/08/26 at 8:45 A.M. that Resident #22's care plan had not been updated to reflect his current behavioral status.</p> <p>Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated 03/01/22, revealed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.</p> <p>2. Review of the medical record for Resident #82 revealed he was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, intracranial injury, post traumatic seizures, and spastic quadriplegic cerebral palsy.</p> <p>Review of the MDS assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 00, that indicated Resident #82 had severe cognition impairment. Review of the MDS assessment revealed Resident #82 was dependent on staff for activities of daily living (ADLs).</p> <p>Review of the care plan dated 05/19/25 revealed Resident #82 had increased risk for falls and an (continued on next page)</p> |                                                                                            |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                            |                                                 |
| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>actual fall related to brain injury with interventions that included ensure a safe environment and anticipation to meet the needs of the resident. Further review of the care plan included additional interventions in keeping call light within reach, handrails on the wall, and bed in lowest position at night.</p> <p>Review of the admission hospital paperwork dated 05/12/25 revealed Resident #82 had a history of traumatic brain injury secondary to a gunshot wound, status post right hemispherectomy with elective right cranioplasty. The resident was wheelchair bound with a seizure disorder and weak in all extremities. Review of the hospital paperwork revealed Resident #82 was a fall risk and required a bed alarm.</p> <p>Review of the fall risk assessment dated [DATE] revealed Resident #82 was a high risk for falls.</p> <p>Review of the admission care conference dated 05/21/25 at 11:00 A.M. revealed Resident #82 had poor safety awareness related to falls and/or fall risk and was dependent for all care.</p> <p>Review of the care conference dated 07/01/25 at 11:13 A.M. revealed Resident #82 was dependent on staff for ADLs. Review of the care conference revealed Resident #82's fall risk was not discussed.</p> <p>Review of the fall risk assessment dated [DATE] revealed Resident #82 had a history of one to two falls within the last six months.</p> <p>Review of the progress notes dated 08/14/25 at 12:31 A.M. revealed Resident #82 had an unwitnessed fall around 12:30 A.M. Registered Nurse (RN) #925 heard a sound that led to Resident #82's room, where he was found with his head down on the right side of his bed with his legs still in the bed. Resident #82 was repositioned in bed and placed back on the ventilator with his oxygen level at 55 percent (%) that increased to 95% less than a minute after. Resident #82, at approximately 12:45 A.M., had an episode of projectile vomiting and was subsequently sent out to the hospital via emergency medical services (EMS) due to his history of right intracranial surgery and presenting symptoms.</p> <p>Review of the fall follow-up assessment dated [DATE] at 12:38 A.M. revealed Resident #82 had a fall with no signs and/or symptoms of bleeding or bruising and fall mats put into place as the new intervention and was effective.</p> <p>Review of the hospital after-visit summary, dated 08/14/25 at 5:39 A.M., revealed Resident #82 was seen in the emergency department for a fall and was subsequently diagnosed with a fall with a head injury (struck left side of the head). Review of the after-visit summary revealed Resident #82 was a high risk for falling upon discharge.</p> <p>Review of the progress note dated 08/14/25 at 8:32 A.M. revealed Resident #82 experienced an unwitnessed fall. Resident #82 fall interventions were put into place.</p> <p>Review of the post fall/incident investigation summary dated 08/14/25, with no time indicated, revealed Resident #82 was observed at bedside, was assessed for range of motion and vital signs were within normal limits. Resident #82's physician and Power of Attorney (POA) were notified, and the fall protocol was followed. Review of the document revealed prior interventions were in place and current interventions consisted of repositioning, neurological checks, and put in place extended bed and extended air mattress. Further review of the document revealed Resident #82 contributing factors (continued on next page)</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                            |                                                 |
| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>leading to the fall included poor bed mobility, decreased safety, and epilepsy. Review of the document revealed Resident #82 had a history of seizure activity, loss of trunk control, impaired posture stability, decreased safety awareness resulting in him sliding out of bed and inability to self-correct or recognize the need for assistance. Review of the document revealed no prior or subsequent implementation of floor mats.</p> <p>Observation on 01/05/26 at 8:30 A.M., 10:45 A.M., 12:15 P.M., and 2:00 P.M. revealed Resident #82 in bed with no fall mats observed in place. Resident #82 was observed to only be able to follow the surveyor with his eyes and slightly shift position of his head. Resident #82 appeared to lack voluntary control of his body.</p> <p>Observation and interview on 01/06/26 at 9:03 A.M. revealed Resident #82 lying in bed with no floor mats in place. Licensed Practical Nurse (LPN) #839 stated Resident #82 was fully dependent on staff for ADLs, was a fall risk, and was required to be checked on every two hours. LPN #839 stated Resident #82 never had fall mats in place as a fall intervention. LPN #839 revealed Resident #82's POA visited frequently and spoke to staff about his care needs. LPN #839 revealed the resident's POA asked about fall mats, but LPN #839 stated, Fall mats are not needed because he cannot move on his own. LPN #839 confirmed and verified the above findings at the time of the interview.</p> <p>Interview on 01/06/26 at 9:10 A.M. with Certified Nurse Aide (CNA) #745 revealed Resident #82 was a fall risk. CNA #745 revealed Resident #82 utilized a special high-back wheelchair to decrease his risk of falls while out of bed. CNA #745 revealed Resident #82 did not have floor mats in place to decrease the risk of injury if he fell out of bed. CNA #745 revealed Resident #82's POA visited him in the facility, wanted fall mats implemented, and had plans on discharging him home. CNA #745 revealed Resident #82's bed, during the day, was in the highest position, but she had never seen it in the lowest position. CNA #745 revealed Resident #82 had a history of seizures that could result in uncontrollable body movements. CNA #745 confirmed and verified Resident #82 did not have floor mats in place and was still a fall risk despite being unable to control his body movements.</p> <p>Interview on 01/07/26 at 1:54 P.M. with Medical Doctor (MD) #926 revealed Resident #82 was at high risk for falls due to his history of rolling out of bed. MD #926 revealed Resident #82 did not communicate well, had severe cognition deficits, and if he was high risk for falls, floor mats were typically an option for intervention.</p> <p>Interview on 01/08/26 at 10:47 A.M. with the Director of Nursing (DON) revealed Resident #82 was admitted to the hospital after a fall and identified as a fall risk due to his medical diagnoses. The DON revealed all residents were assessed for fall risk upon admission and information provided from other sources was taken into consideration. The DON revealed prior to Resident #82's fall, there were no fall mats in place, and after his fall, she implemented an extended bed as a result of the fall. The DON revealed she did not put floor mats in place as she felt it was not needed as a result of her assessment.</p> <p>Interview on 01/08/26 at 3:08 P.M. with Resident #82's POA revealed the resident was completely dependent on staff for all ADLs. The POA revealed Resident #82 was unable to care for himself and had a history of seizures which resulted in him being a high fall risk. The POA revealed prior to admission to the facility, Resident #82 had a history of sliding out of bed, seizures, and that she informed the facility staff upon admission. The POA revealed she requested fall mats to be placed down as a safety precaution due to his history of a gunshot wound to the head, traumatic brain surgery, and his falls out of bed. The POA revealed Resident #82 sustained a fall out of bed and hit his (continued on next page)</p> |                                                                                            |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                            |                                                 |
| F 0657<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>head that resulted in swelling, bruising, and scratches to his face. The POA revealed after multiple requests, the facility staff refused to put fall mats in place. The POA revealed she was currently planning to discharge Resident #82 home.</p> <p>Review of the facility policy titled, Comprehensive Person-Centered Care Plans, revised March 2022, revealed the interdisciplinary team in conjunction with the resident and/or his family or legal representative developed and implemented a care plan for each resident. Review of the policy revealed each resident and/or representative had a right to participate and request meetings and revisions to the plan of care.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2597600.</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                            |                                                 |
| <p>F 0677</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, medical record review, review of shower sheets and schedules, resident interview, resident representative interview, staff interview, and facility policy review, the facility failed to ensure residents were provided with appropriate care and assistance with their activities of daily living. This affected three (#10, #25, and #73) of three residents reviewed for activities of daily living. The census was 92. Findings include: 1. Review of the medical record for Resident #73 revealed an admission date of 07/11/25. Diagnoses included Parkinsonism, dementia, and muscle weakness.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment revealed the resident was cognitively intact. She required supervision/touching assistance for eating.</p> <p>Review of the January 2026 physician orders revealed orders for a divided plate, weight utensils, and a sippy cup with lid and straw.</p> <p>Review of the care plan initiated on 07/23/25 revealed Resident #73 had a goal to maintain activities of daily living (ADLs). Interventions included supervision/set-up by one staff to eat, revised on 11/06/25, and Resident #73's usual performance was partial assistance with meals which was initiated on 11/14/25.</p> <p>Review of the progress note dated 01/02/26 and timed for 12:11 P.M. revealed Resident #73 was placed in the dining area for close watch. Meals were served and fed.</p> <p>Observation on 01/08/25 at 12:25 P.M. revealed a certified nurse aide (CNA) placed a plate in front of Resident #73 who was sitting at a table across from the nursing station. Both CNA #736 and CNA #763 continued to pass lunch to the rest of the residents in the dining room for approximately eight residents. Continued observation revealed both CNAs left the dining room. At approximately 12:29 P.M., the surveyor heard a continuous banging and looked up to see Resident #73 holding her weighted spoon in her right hand and it was striking her divided plate as she tried to scoop her food onto her spoon. She continued to attempt to get food onto her spoon by using her left hand to push the food without success. At 12:40 P.M., Resident #73 was observed holding her plate with her left hand and the plate was held with her right hand, but was halfway off the table at an angle. Staff members were observed passing in the hallway behind the nursing station. At 12:41 P.M., Resident #73 nearly dropped her plate with food falling to the ground at 12:42 P.M. Agency Registered Nurse (ARN) #870 came to the dining room just as this happened. ARN #870 helped push the resident closer to the table and picked up her plate. ARN #870 put on gloves and pulled up a seat to assist. ARN #870 cleaned off Resident #73's lap. ARN #870 observed Resident #73 for a few minutes and encouraged her to eat, turning the plate. ARN #870 picked up the spoon at 12:45 P.M. to start feeding the resident. Resident #73 ate approximately six bites of food and no additional food was offered to replace what fell on the floor. CNA #736 came into the dining room and swept up the food on the floor.</p> <p>Interview on 01/07/26 at 12:52 P.M. with ARN #870 stated she was from a staffing agency and had not been to the facility in months. She was not aware of Resident #73's assistance needs; however, she saw the plate falling and went to assist her. She was not certain of the policy on staff supervising in the dining room, but verified no one had been in there assisting Resident #73 with eating prior to her.</p> <p>Interview on 01/07/26 at 2:40 P.M. the Corporate Nurse revealed her response when told about no (continued on next page)</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |                                                 |
| <p>F 0677</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>supervision or assistance for Resident #73 at lunch was asking if staff were loosely supervising and, Did the resident want to eat?.</p> <p>Interview on 01/07/26 at 3:20 P.M., with the Director of Nursing (DON) revealed the facility used acuity as far as supervision in dining room and verified 15 minutes without assistance was not acceptable.</p> <p>Interview on 01/08/26 at 11:45 A.M. with Licensed Practical Nurse (LPN) #793, a nurse familiar with Resident #73, stated the resident required assistance with eating and the CNAs knew they had to help her.</p> <p>Review of facility policy titled, Food and Nutrition Services, last revised October 2017, revealed nurse aides will provide support to enhance resident experience.</p> <p>2. Review of the medical record for Resident #10 revealed and admission date of 02/09/21. Diagnoses included but were not limited to hemiplegia and hemiparesis, neuromuscular dysfunction of bladder, and chronic kidney disease.</p> <p>Review of the MDS assessment dated [DATE] for Resident #10 revealed a Brief Interview of Mental Status (BIMS) score of 14 which indicated the resident had intact cognition. Resident #10 was noted to required maximum assistance of staff for bathing.</p> <p>Review of the care plan for Resident #10, last reviewed on 01/02/26, revealed a performance deficit related to disease process. Resident #10 was noted to require staff assistance to complete ADLs including bathing.</p> <p>Review of Resident #10's nursing progress notes for the past from August 2025 to January 2026 did not reveal any notes related to refusal of bathing.</p> <p>Interview on 01/06/26 at 10:52 A.M. with Resident #10 revealed she was not always bathed and stated sometimes the staff give excuses why they are unable to bathe her.</p> <p>Interview on 01/07/26 at 9:59 A.M. with CNA #742 revealed Resident #10 was scheduled for bathing on Wednesdays and Saturdays and stated she does not usually refuse bathing.</p> <p>Review of the facility shower schedule for Resident #10 revealed bathing was to be provided on Wednesdays and Saturdays between 7:00 A.M. and 3:00 P.M.</p> <p>Review of the October 2025 calendar revealed eight opportunities for Resident #10 to be bathed on Wednesdays and Saturdays (10/01/25, 10/04/25, 10/08/25 (the resident was in the hospital), 10/11/25, 10/15/25, 10/18/25, 10/22/25, 10/25/25, and 10/29/25).</p> <p>Review of the facility provided shower sheets for October 2025 for Resident #10 revealed an incomplete form was provided for 10/04/25, a shower was provided on 10/15/25, and 10/18/25. No additional evidence of bathing sheets was provided. Evidence of bathing was provided two times out of eight opportunities in October 2025.</p> <p>Review of the November 2025 calendar provided nine opportunities for Resident #10 to be bathed on Wednesdays and Saturdays (11/01/25, 11/05/25, 11/08/25, 11/12/25, 11/15/25,11/19/25, (continued on next page)</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                            |                                                 |
| <p>F 0677</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>11/22/25, 11/26/25, and 11/29/25).</p> <p>Review of the facility provided shower sheets for November 2025 for Resident #10 revealed an incomplete form was provided for 11/02/25, a shower on 11/05/25, a shower on 11/08/25, a shower on 11/12/25, a shower on 11/15/25 and a bed bath on 11/19/25. Evidence of bathing was provided five times out of nine opportunities for November 2025.</p> <p>Review of the December 2025 calendar revealed seven opportunities for Resident #10 to be bathed (12/03/25, 12/06/25, 12/10/25 (the resident was in the hospital), 12/13/25 (the resident was in the hospital), 12/17/25, 12/20/25, 12/24/25, 12/27/25, and 12/31/25).</p> <p>Review of the facility provided shower sheets for December 2025 for Resident #10 revealed a shower was given on 12/03/25, an incomplete shower form for 12/06/25, a bed bath was given on 12/17/25, a shower was given on 12/20/25, an incomplete form on 12/24/25, a shower was given on 12/27/25, and a shower was given on 12/31/25. Evidence of bathing was provided for five out of seven opportunities.</p> <p>3. Review of the medical record for Resident #25 revealed an admission date of 12/27/19. Diagnoses included but were not limited to severe dementia with behaviors, vascular dementia and generalized anxiety disorder.</p> <p>Review of the MDS assessment dated [DATE] for Resident #25 revealed a BIMS score of three which indicated the resident had severe cognitive impairment. Resident #25 was noted to required moderate assistance of staff for bathing and rejection of care was not indicated.</p> <p>Review of Resident #25's nursing progress notes from August 2025 to January 2026 did not indicate any noted bathing refusals.</p> <p>Review of the bathing care plan for Resident #25 revealed it was last revised on 07/22/25. Resident #25 was noted to have a self-care performance deficit related to the aging process and required staff assistance to complete ADLs. Resident #25 was noted to require moderate assistance for bathing routinely and as necessary.</p> <p>Interview on 01/06/26 at 12:35 P.M. with Resident #25's daughter revealed her mother needed assistance at times with bathing. She stated she frequently visited the facility and Resident #25 was still in her pajamas and felt she was not getting bathed at least twice a week.</p> <p>Review of the facility bathing schedule revealed Resident #25 was scheduled for bathing on Tuesdays and Fridays between 7:00 A.M. and 3:00 P.M.</p> <p>Review of the October 2025 calendar revealed nine bathing opportunities (10/03/25, 10/07/25, 10/10/25, 10/14/25, 10/17/25, 10/21/25, 10/24/25, 10/28/25, and 10/31/25) for Resident #25.</p> <p>Review of the facility provided bathing sheets for Resident #25 revealed a refusal on 10/03/25 but did not indicate if resident was reapproached at a later time, a shower was given on 10/10/25, a refusal on 10/17/25 but did not indicate she was reapproached at a later time, and a refusal on 10/24/25 which also did not indicate she was approached at a later time for a second attempt. Evidence provided by the facility indicated Resident #25 was offered bathing four out of nine opportunities.<br/>(continued on next page)</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                                                 |
| <p>F 0677</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Review of the November 2025 calendar revealed eight bathing opportunities (11/04/25, 11/07/25, 11/11/25, 11/14/25, 11/18/25, 11/21/25, 11/25/25 and 11/28/25) for Resident #25.</p> <p>Review of the facility provided bathing sheets for November 2025 for Resident #25 revealed an incomplete form for 11/04/25, a shower was given on 11/07/25, a shower on 11/18/25, a refusal on 11/21/25 which did not indicate a second attempt for bathing was made, and a bed bath was given on 11/28/25. Evidence provided by the facility indicated Resident #25 was offered bathing four out of eight opportunities.</p> <p>Review of the December 2025 calendar for Resident #25 revealed nine bathing opportunities (12/02/25, 12/05/25, 12/09/25, 12/12/25, 12/16/25, 12/19/25, 12/23/25, 12/26/25, 12/30/25).</p> <p>Review of the facility provided bathing sheets for December 2025 for Resident #25 revealed a bed bath was given on 12/02/25, a shower was given on 12/05/25, a refusal on 12/12/25 which did not indicate an additional attempt being made, a refusal on 12/19/25 which also did not indicate an additional attempt being made, and a form dated 12/26/25 which had a nurse signature but no additional information. The facility provided evidence for four of nine bathing opportunities.</p> <p>Interview on 01/07/26 at 6:40 A.M. with LPN #772 revealed Resident #25 will sometimes refuse bathing and it should be documented.</p> <p>Interview on 01/07/26 at 4:18 P.M. with the DON revealed residents are scheduled to be bathed twice a week and if a resident refused, staff are to ask several times and document the refusals. If they still refuse after a couple days, they are supposed to notify the family and physician to encourage them to shower. The CNAs are to complete the shower sheets and supposed to notify the nurse when they are providing bathing so the nurse can do a skin check. Both the nurse and the nurse aide are to sign the form once it is complete.</p> <p>Interview on 01/08/26 at 2:22 P.M. with Assistant Director of Nursing (ADON) #727 confirmed she provided additional shower sheets, but the information that was added was because she had called some of the staff after the fact to add information to the incomplete shower sheets. ADON #727 confirmed the shower sheets for Resident #10 and Resident #25 originally provided by the facility were not completed twice weekly as required.</p> <p>Review of the facility policy titled, Shower/Tub Bath, dated October 2010, revealed the following documentation should be recorded on the resident's ADLs record and/or in the resident's medical record: the date and time the shower/tub bath was performed, the name and title of the individual(s) who assisted the resident with the shower/tub bath, all assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath, how the resident tolerated the shower/tub bath, if the resident refused the shower/tub bath, the reason(s) why and the intervention taken, the signature and title of the person recording the data.</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, medical record review, hospital document review, review of fall investigations, resident representative interview, staff interview, and policy review, the facility failed to ensure appropriate fall interventions were implemented and consistently in place to prevent falls. This affected one (#82) of three residents reviewed for falls. The facility census was 92. Findings include: Review of the medical record for Resident #82 revealed he was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, intracranial injury, post traumatic seizures, and spastic quadriplegic cerebral palsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 00, that indicated Resident #82 had severe cognition impairment. Review of the MDS assessment revealed Resident #82 was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 05/19/25 revealed Resident #82 had increased risk for falls and an actual fall related to brain injury with interventions that included ensure a safe environment and anticipation to meet the needs of the resident. Further review of the care plan included additional interventions in keeping call light within reach, handrails on the wall, and bed in lowest position at night. Review of the admission hospital paperwork dated 05/12/25 revealed Resident #82 had a history of traumatic brain injury secondary to a gunshot wound, status post right hemispherectomy with elective right cranioplasty. The resident was wheelchair bound with a seizure disorder and weak in all extremities. Review of the hospital paperwork revealed Resident #82 was a fall risk and required a bed alarm. Review of the fall risk assessment dated [DATE] revealed Resident #82 was a high risk for falls. Review of the admission care conference dated 05/21/25 at 11:00 A.M. revealed Resident #82 had poor safety awareness related to falls and/or fall risk and was dependent for all care. Review of the fall risk assessment dated [DATE] revealed Resident #82 had a history of one to two falls within the last six months. Review of the progress notes dated 08/14/25 at 12:31 A.M. revealed Resident #82 had an unwitnessed fall around 12:30 A.M. Registered Nurse (RN) #925 heard a sound that led to Resident #82's room, where he was found with his head down on the right side of his bed with his legs still in the bed. Resident #82 was repositioned in bed and placed back on the ventilator with his oxygen level at 55 percent (%) that increased to 95% less than a minute after. Resident #82, at approximately 12:45 A.M., had an episode of projectile vomiting and was subsequently sent out to the hospital via emergency medical services (EMS) due to his history of right intracranial surgery and presenting symptoms. Review of the fall follow-up assessment dated [DATE] at 12:38 A.M. revealed Resident #82 had a fall with no signs and/or symptoms of bleeding or bruising and fall mats put into place as the new intervention and was effective. Review of the hospital after-visit summary, dated 08/14/25 at 5:39 A.M., revealed Resident #82 was seen in the emergency department for a fall and was subsequently diagnosed with a fall with a head injury (struck left side of the head). Review of the after-visit summary revealed Resident #82 was a high risk for falling upon discharge. Review of the progress note dated 08/14/25 at 8:32 A.M. revealed Resident #82 experienced an unwitnessed fall. Resident #82 fall interventions were put into place. Review of the post fall/incident investigation summary dated 08/14/25, with no time indicated, revealed Resident #82 was observed at bedside, was assessed for range of motion and vital signs were within normal limits. Resident #82's physician and Power of Attorney (POA) were notified, and the fall protocol was followed. Review of the document revealed prior interventions were in place and current interventions consisted of repositioning, neurological checks, and put in place extended bed and extended air mattress. Further review of the document revealed Resident #82 contributing factors leading to the fall included poor bed mobility, decreased safety, and epilepsy. Review of the document revealed Resident #82 had a history of seizure activity, loss of trunk control, impaired posture stability, decreased safety awareness resulting in him sliding out of bed and inability to self-correct (continued on next page)</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                            |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>or recognize the need for assistance. Review of the document revealed no prior or subsequent implementation of floor mats. Observation on 01/05/26 at 8:30 A.M., 10:45 A.M., 12:15 P.M., and 2:00 P.M. revealed Resident #82 in bed with no fall mats observed in place. Resident #82 was observed to only be able to follow the surveyor with his eyes and slightly shift position of his head. Resident #82 appeared to lack voluntary control of his body. Observation and interview on 01/06/26 at 9:03 A.M. revealed Resident #82 lying in bed with no floor mats in place. Licensed Practical Nurse (LPN) #839 stated Resident #82 was fully dependent on staff for ADLs, was a fall risk, and was required to be checked on every two hours. LPN #839 stated Resident #82 never had fall mats in place as a fall intervention and confirmed the above findings at the time of the interview. Interview on 01/06/26 at 9:10 A.M. with Certified Nurse Aide (CNA) #745 revealed Resident #82 was a fall risk. CNA #745 revealed Resident #82 utilized a special high-back wheelchair to decrease his risk of falls while out of bed. CNA #745 revealed Resident #82 did not have floor mats in place to decrease the risk of injury if he fell out of bed. CNA #745 revealed Resident #82's bed, during the day, was in the highest position, but she had never seen it in the lowest position. CNA #745 revealed Resident #82 had a history of seizures that could result in uncontrollable body movements. CNA #745 confirmed and verified Resident #82 did not have floor mats in place and was still a fall risk despite being unable to control his body movements. Interview on 01/08/26 at 10:47 A.M. with the Director of Nursing (DON) revealed Resident #82 was admitted to the hospital after a fall and identified as a fall risk due to his medical diagnoses. The DON revealed all residents were assessed for fall risk upon admission and information provided from other sources was taken into consideration. The DON revealed prior to Resident #82's fall, there were no fall mats in place, and after his fall, she implemented an extended bed as a result of the fall. The DON revealed she did not put floor mats in place as she felt it was not needed as a result of her assessment. Review of the facility document titled, Managing Falls and Fall Risk, revised December 2007, revealed that based on previous evaluations and current data staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and minimize complications from falling. The staff will monitor and document each resident's response to interventions intended to reduce falling or risk of falling. This deficiency represents non-compliance investigated under Complaint Number 2597600.</p> |                                                                                            |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>01/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solon Pointe at Emerald Ridge                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5625 Emerald Ridge Parkway<br>Solon, OH 44139 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                                                 |
| <p>F 0759</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were administered as ordered to prevent a medication error rate of less than five (5) percent (%). A total of two medication errors were observed out of 29 opportunities for a medication error rate of 6.9%. This affected one (#57) of four residents observed for medication administration. The census was 92. Findings include: Review of Resident #57's medical record revealed he was admitted [DATE] and had diagnoses including unspecified dementia, paranoid schizophrenia, and chronic gout. Review of Resident #57's physician orders revealed the resident was ordered fish oil 1200 milligrams (mg) once daily on 10/20/23, and was ordered vitamin D3 on 06/07/23 with instructions to give one tablet daily but had no dosage specified. Observation of a medication administration for Resident #57 by Licensed Practical Nurse (LPN) #840 on 01/07/25 at 9:02 A.M. revealed she administered one 1000 unit pill of vitamin D3 and one 1000 mg pill of fish oil. Interview with LPN #840 on 01/07/25 at 10:07 A.M. confirmed she administered 1000 mg of fish oil to Resident #57 and the order indicated to give 1200 mg, and confirmed she administered 1000 units of vitamin D3 to Resident #57 without clarify what dosage was to be given. Following surveyor intervention, the facility took steps to obtain the correct dosage of fish oil and obtained a new order with clarification of the vitamin D3 dosage. Record review of the facility's medication administration policy, dated 04/2019, revealed the individual giving the medication was to verify the correct medication and dosage before giving the medication.</p> |                                                                                            |                                                 |