STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366270	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Pointe Skilled Nursing & Rehab	87 Staley Road Orwell, OH 44076

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, interview and review of the facility policy, the facility failed to ensure labs were obtained as ordered for Resident #5. This affected one resident (#5) out of five residents reviewed for unnecessary medications/labs. The facility census was 50. Findings include: Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including diabetes, dementia, hypertension, and seizures. Review of the lab work completed from 02/25/23 to 03/18/25 revealed there was no documented evidence a ferritin level (lab that indicated the amount of iron stored in the body) or a Keppra level (lab that monitored the anticonvulsant (seizure) drug level) was completed as ordered. A Vitamin D level was completed on 07/15/24 and was 17 indicating it was low (normal range was 30 to 100 nanograms (ng)/ milliliter (mL). There were no further Vitamin D levels noted on review. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had intact cognition and was on an anticonvulsant medication. Review of the March 2025 physician's orders revealed Resident #5 had a physician order dated 02/25/23 to have a Complete Blood Count (CBC), Hemoglobin A1c (HbA1c), Liver Function Test, Lipid Panel, Thyroid-Stimulating Hormone (TSH), Keppra, Vitamin D and Ferritin levels every six months. Resident #5 had an order for Vitamin D3 50,000 units one capsule every Monday morning, and Keppra 500 milligram (mg) tablet by mouth two times a day for seizures. Interview on 03/19/25 at 11:02 A.M. with the Director of Nursing (DON) verified there was no documented evidence a Keppra level and/or a Ferritin level was completed since admission. The last Vitamin D level was completed on 07/15/24, and it should have been completed every six months. She verified that the Vitamin D level should have been done 01/15/25. Review of the facility policy labeled, Lab and Diagnostic Test Results- Clinical Protocol, last revised November 2018, revealed the physician would identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The policy revealed the staff would process test requisitions and arrange for tests.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51525 Based on record review, interview and facility policy review, the facility failed to provide culturally competent, trauma-informed care in accordance with professional standards of practice or account for experience and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of Resident #52's post-traumatic stress disorder (PTSD). This affected one resident (#52) of two residents reviewed for trauma informed care. The facility census was 50. Findings include: Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses of PTSD, morbid (severe) obesity due to excess calories, and anxiety disorder. Review of the undated comprehensive care plan revealed the absence of a care plan addressing PTSD or associated triggers and the absence of a psychosocial assessment for Resident #52. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #52 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Interview with Resident #52 on 03/17/25 at 8:35 A.M. revealed a history of PTSD from sexual abuse as a minor and a sexual assault that occurred in the shower room of the nursing facility (NF) where he previously lived. He stated his triggers were the shower room in the NF and having to receive personal care from male staff members. Resident #52 stated he had requested to not have male caregivers and stated the facility had honored that request. He further stated he frequently refused showers and preferred bed baths because of his triggers. Interview with Resident #52 on 03/18/25 at 8:26 A.M. revealed he was receiving supportive services from contracted Psychological Services and enjoyed talking with his counselor. He also stated he felt very safe in this facility. Interview with Social Service Designee (SSD) #743 on 03/18/25 at 3:37 P.M. revealed psychosocial assessments were not completed for all residents. She stated she didn't complete psychosocial assessments unless the MDS nurse instructed her to do so. SSD #743 also stated the MDS nurse completed all care plans for all residents' psychosocial issues. Interview with the MDS/Licensed Practical Nurse (LPN) #727 on 03/18/25 at 3:45 P.M. revealed her understanding was contracted Psychological Services would complete psychosocial assessments on all residents. MDS/LPN #727 stated she was unsure who provided staff in-services and education about PTSD. She verified the absence of a care plan for PTSD and the absence of a psychosocial assessment. Interview with LPN #736 on 03/19/25 at 12:33 P.M. revealed she was aware of Resident #52's request for no male caregivers but was unaware of other PTSD triggers. LPN #736 further stated the facility had a male aide on night shift, but all staff knew not to allow him to provide care to Resident #52. LPN #736 stated those instructions were not written down anywhere but were passed along in report. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Certified Nursing Assistant (CNA) #750 on 03/19/25 at 12:35 P.M. revealed she was unaware of any of Resident #52's PTSD triggers, was never told about triggers and had never been educated about the resident's history of PTSD or triggers associated with his diagnosis of PTSD. Review of the facility policy titled Trauma Informed Care and Culturally Competent Care, dated 2001, revealed the facility would perform universal screening of residents for exposure to traumatic events, utilize screening tools and methods that were facility-approved, competently delivered, culturally relevant and sensitive, and utilize initial screening to identify the need for further assessment and care. The policy further stated the facility would complete an assessment that would evaluate the presence of PTSD symptoms, their relationship to trauma and the identification of triggers. The policy also stated the facility would develop an individualized care plan that addressed past trauma to identify and decrease exposure to triggers that may re-traumatize the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #43 had adaptive equipment as ordered when eating. This affected one resident (#43) out of one resident reviewed for adaptive equipment when eating. This had the potential to affect seven residents (#5, #10, #11, #17, #30, #32, and #43) that had orders for adaptive equipment while eating. The facility census was 50. Findings included: Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including multiple sclerosis, muscle weakness, and schizoaffective disorder. Review of the March 2025 physician's orders revealed Resident #43 had an order dated 11/03/23 to have built-up utensils and a two handled mug for all meals. Review of the care plan dated 03/11/25 revealed Resident #43 had a nutritional problem related to excessive energy intake and self-feeding deficit which required adaptive equipment with meals. Interventions included occupational therapy screening and providing adaptive equipment for feeding including non-spill cups and built-up utensils. Observation on 03/17/25 at 8:06 A.M. revealed there was no adaptive equipment on Resident #43's meal tray including built-up utensils and a two handled mug. Resident #43 refused her breakfast tray. Review of the Meal Ticket on Resident #43's meal tray dated 03/18/25 revealed there was no indication she was to have adaptive equipment while eating including built- up utensils and/or a two handled mug. Interview on 03/18/25 at 11:48 A.M. with Certified Nursing Assistant (CNA) #737 revealed Resident #43 did not have any adaptive equipment for meals. She had never seen adaptive equipment on her tray including built-up utensils and a two handled mug. Observation on 03/18/25 at 12:15 P.M. revealed Resident #43 was in her room eating. She had regular silverware and a plastic cup without two handles. Interview on 03/18/25 at 12:15 P.M. with Resident #43 revealed she never received built-up utensils and/or a two handled mug. She revealed she did not feel they were necessary as she felt she ate and drank without any difficulty. Interview on 03/18/25 at 12:19 P.M. with Licensed Practical Nurse (LPN) #733 verified Resident #43 had a physician's order to receive built-up utensils and a two handled mug. She verified the adaptive equipment was not on her tray, and the kitchen was responsible for ensuring anyone with adaptive equipment had it on their meal tray. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/18/25 at 12:27 P.M. with Dietary Manager #746 revealed she started in November 2024 and stated I will be honest, when started it was a cluster mess because the adaptive equipment that she had in the kitchen did not match what nursing had as orders. She revealed she had been meaning to complete an audit to ensure they matched but had not had a chance. She verified Resident #43's meal ticket did not have that Resident #43 was to receive adaptive equipment including built-up utensils and a two handled mug. Interview on 03/18/25 at 1:12 P.M. with Dietician #747 revealed she was not aware Resident #43 had a physician's order to receive built-up utensils and/or a two handled mug. Review of the facility policy labeled, Assistive Devices and Equipment, dated 2001, revealed the facility maintains and supervises the use of assistive devices and equipment for residents. Certain devices and equipment that assisted with resident mobility, safety, and independence were provided for residents that may include specialized eating utensils and equipment. The policy recommended the use of devices and equipment was based on comprehensive assessment and documented in the resident care plan.