STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366352	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Pointe Health and Rehab Ctr	100 Michelli Street Barnesville, OH 43713

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, interview, review of camera footage, employee statement review and policy review, the facility failed to provide care and services, including appropriate supervision levels, to prevent resident neglect. This affected one resident (Resident #10) of three residents reviewed for neglect. The facility census was 58. Findings included: Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, muscle weakness, osteoporosis, vertigo, anxiety, and restlessness and agitation. Review of Resident #10's care plan, dated 05/23/23, revealed the resident was at risk for alteration in comfort with interventions including to reposition the resident for comfort. Further review revealed the resident was at risk for falls related to weakness, poor safety awareness, osteoporosis, glaucoma, vertigo, and anxiety with interventions including to encourage and remind the resident to ask for assistance and to monitor/anticipate/intervene for causative factors. Review of the care plan, dated 09/23/24, revealed the resident had an alteration in skin integrity as evidenced by moisture-associated skin damage (MASD) of the right buttock with interventions including to provide skin care as needed. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/09/24, revealed Resident #10 was severely cognitively impaired and required moderate/substantial staff assistance with toileting and showers/baths. The assessment indicated the resident was occasionally incontinent of urine and was at risk for developing pressure ulcers. Review of the facility's Fall Investigation, dated 10/28/24, revealed on 10/28/24 at 7:45 A.M., Resident #10 was observed in her room, on her bottom with her feet in front of her. She was incontinent of urine, fully dressed, and wearing anti-skid socks. The resident was wincing in pain, but unable to tell where the pain was located. Range of Motion (ROM) was within normal limits and vital signs were stable. The resident was assisted up with the assistance of three staff. The physician and the family were notified. (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress note, dated 10/28/24 at 10:15 A.M. (noted as a late entry), revealed Resident #10's daughter contacted the nurse regarding her mother's fall. Resident #10 was reassessed for injury by performing a head to toe assessment. Vitals signs were at baseline and the resident showed no visible signs of injury. Soreness was apparent with range of motion (ROM). The resident was assisted to bed and no pain medication was required. The resident was resting comfortably with call light in place. Review of nursing progress noted, dated 10/30/24 at 1:14 P.M., revealed the physician reviewed the x-ray of the left wrist and stated there is no suspicion of a fracture per his assessment. Review of the camera footage provided by Resident #10's Family Member #20 dated/timestamped 10/27/24 at 10:57 P.M. through 10/28/24 at 4:42 A.M., revealed Resident #10 was located on the floor in front of her recliner, in either a sitting, reclining, or lying position. Review of CNA #60's Witness Statement, dated 10/28/24 at 4:00 P.M., revealed Resident #10 was in her recliner and had no issues or complaints. CNA #60 stated she did not check on the resident for the rest of the night shift because the resident is usually independent and will come into the hall if she needs anything. CNA #60 stated she was aware of the two hour check and change standard, however, she thought Resident #10 would come out into the hall to get her if she needed anything. Interview on 11/12/24 at 1:29 P.M. with Resident #10 revealed she could not recall the incident on 10/27/24. Interview on 11/12/24 at 2:00 P.M. with Human Resources Director #50 revealed Certified Nursing Assistant (CNA) #60 was terminated following the incident of lack of care for Resident #10 on 10/27/24. Interview on 11/12/24 at 2:51 P.M. with Registered Nurse (RN) #64 revealed she worked on 10/27/24 until 11:00 P.M. RN #64 stated she last observed Resident #10 sitting in her recliner, and she appeared to be happy and in no distress, with ice water on her bedside table and her call light within reach. RN #64 stated that she administered Resident #10's medications and left the room. Interview on 11/12/24 at 3:15 P.M. with Director of Nursing (DON) revealed it was her expectation that the staff should do rounds every two hours. The DON stated Resident #10 did prefer to have her door closed and would sometimes get upset if she was awakened, however, staff should still observe the resident. The DON confirmed CNA #60 was terminated due to the incident on 10/27/24 involving Resident #10. Interview on 11/12/24 at 3:32 P.M. with Administrator revealed he was notified in the morning of 10/28/24 by RN #67 that Resident #10 was found on the floor when her breakfast tray was delivered, and the Resident's daughter was on the phone and upset. The Administrator stated he spoke with Resident #10's daughter on the phone and assured her that a full investigation would be initiated. It was determined through interviews that CNA #60 did not check on the resident after 10:30 P.M. and the resident did not receive proper care. The Administrator stated that he did not believe there was malice or willful neglect on the part of CNA #60; however, the Administrator stated CNA #60 was terminated because this is not something we are comfortable with and not our standard of care. Interview on 11/12/24 at 3:38 P.M., Corporate RN #240 confirmed Resident #10 was a fall risk and on a toileting program and should have been checked on multiple times throughout the night. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated 11/21/2016, revealed it is the facility's policy to investigate all alleged violation involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property. Additionally, the facility should immediately report all such allegations to the Administrator and to the state agency. The definition of neglect is the failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the facility policy titled, Resident Supervision, dated 06/11/24, revealed it is the policy of this facility to ensure residents receive adequate supervision and assistance, while making every attempt to balance safety needs, resident rights, and quality of life issues that will positively impact each resident's individual situation. As a result of the incident, the facility took the following actions to correct the deficient practice by 10/30/24: Immediately following notification of the incident on 10/28/24, Resident #10 was assessed for injury by Licensed Practical Nurse (LPN) #67. The Unit Nurse immediately notified the physician and family. X-rays were ordered on 10/28/24 by physician at the family's request. The x-rays resulted negative. Interviews were conducted by the Administrator and Human Resources Director on 10/28/24 with staff who were working on 10/27/24 night shift into the morning on 10/28/24. Initial audit completed on 10/28/24 by the Minimum Data Set (MDS) nurse and Assistant Director of Nursing (ADON) of like residents who keep their door shut when in room, independent for most activities of daily living (ADLs), residents who keep to themselves and don't like disruption, resistant to care. Care plans were reviewed for those identified. Staffing numbers were reviewed by the Administrator on 10/28/24 to ensure proper staffing numbers for the acuity of the facility. Staffing was found to be appropriate for care needs. Fall during the last 90 days were reviewed by the Regional Clinician on 10/29/24 and completed on 10/30/24 with fall interventions noted to be appropriate. Direct care staff and licensed staff were reeducated by the Administrator, ADON, and HR Director on 10/28/24 the fall management policy, falls best practice and ensuring supervision and care rounds of residents throughout the shift. Education was completed via conference call with 100% participation. Ongoing audits were initiated on 10/28/24 by the Administrator/and or designee weekly for four weeks or as directed by the Quality Assurance (QA) committee, observational rounds to ensure safety checks/routine rounds are being conducted by the direct care staff. Negative findings will be corrected by reeducation of staff and performing a round ensuring the safety/wellbeing of current residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ongoing audits were initiated on 10/28/24 by the Administrator/and or designee weekly for four weeks or as directed by the Quality Assurance (QA) committee, the Administrator or designee will interview five random residents to ensure their needs are met timely and that the residents are being checked on consistently by staff. Negative findings will be corrected by reeducating staff. QA committee meeting will be conducted weekly for four weeks to review audit results. This deficiency represents non-compliance investigated under Complaint Number OH00159347.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, interview, review of camera footage, employee statement review, self-reported incident review, and policy review, the facility failed to report an allegation of resident neglect to the state survey agency This affected one (Resident #10) of three residents reviewed for neglect. The facility census was 58 Findings include: Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, muscle weakness, osteoporosis, vertigo, anxiety, and restlessness and agitation. Review of Resident #10's care plan, dated 05/23/23, revealed the resident was at risk for alteration in comfort with interventions including to reposition the resident for comfort. Further review revealed the resident was at risk for falls related to weakness, poor safety awareness, osteoporosis, glaucoma, vertigo, and anxiety with interventions including to encourage and remind the resident to ask for assistance and to monitor/anticipate/intervene for causative factors. Review of the care plan, dated 09/23/24, revealed the resident had an alteration in skin integrity as evidenced by moisture-associated skin damage (MASD) of the right buttock with interventions including to provide skin care as needed. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/09/24, revealed Resident #10 was severely cognitively impaired and required moderate/substantial staff assistance with toileting and showers/baths. The assessment indicated the resident was occasionally incontinent of urine and was at risk for developing pressure ulcers. Review of the facility's Fall Investigation, dated 10/28/24, revealed on 10/28/24 at 7:45 A.M., Resident #10 was observed in her room, on her bottom with her feet in front of her. She was incontinent of urine, fully dressed, and wearing anti-skid socks. The resident was wincing in pain, but unable to tell where the pain was located. Range of Motion (ROM) was within normal limits and vital signs were stable. The resident was assisted up with the assistance of three staff. The physician and the family were notified. Review of nursing progress note, dated 10/28/24 at 10:15 A.M. (noted as a late entry), revealed Resident #10's daughter contacted the nurse regarding her mother's fall. Resident #10 was reassessed for injury by performing a head to toe assessment. Vitals signs were at baseline and the resident showed no visible signs of injury. Soreness was apparent with range of motion (ROM). The resident was assisted to bed and no pain medication was required. The resident was resting comfortably with call light in place. Review of the camera footage provided by Resident #10's Family Member #20 dated/timestamped 10/27/24 at 10:57 P.M. through 10/28/24 at 4:42 A.M., revealed Resident #10 was located on the floor in front of her recliner, in either a sitting, reclining, or lying position. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA #60's Witness Statement, dated 10/28/24 at 4:00 P.M., revealed Resident #10 was in her recliner and had no issues or complaints. CNA #60 stated she did not check on the resident for the rest of the night shift because the resident is usually independent and will come into the hall if she needs anything. CNA #60 stated she was aware of the two hour check and change standard, however, she thought Resident #10 would come out into the hall to get her if she needed anything. Review of the Self-Reported Incidents submitted to the state survey agency (from this provider) between 10/28/24 and 11/14/24 did not include any SRI reports that pertained to Resident #10 and an allegation of neglect. Interview on 11/12/24 at 2:00 P.M. with Human Resources Director #50 revealed Certified Nursing Assistant (CNA) #60 was terminated following the incident of lack of care for Resident #10 on 10/27/24. Interview on 11/12/24 at 3:15 P.M. with Director of Nursing (DON) revealed it was her expectation that the staff should do rounds every two hours. The DON stated Resident #10 did prefer to have her door closed and would sometimes get upset if she was awakened, however, staff should still observe the resident. The DON confirmed CNA #60 was terminated due to the incident on 10/27/24 involving Resident #10. Interview on 11/12/24 at 3:32 P.M. with Administrator revealed he was notified in the morning of 10/28/24 by RN #67 that Resident #10 was found on the floor when her breakfast tray was delivered, and the Resident's daughter was on the phone and upset. The Administrator stated he spoke with Resident #10's daughter on the phone and assured her that a full investigation would be initiated. It was determined through interviews that CNA #60 did not check on the resident after 10:30 P.M. and the resident did not receive proper care. The Administrator stated that he did not believe there was malice or willful neglect on the part of CNA #60; however, the Administrator stated CNA #60 was terminated because this is not something we are comfortable with and not our standard of care. The Administrator confirmed he did not report the incident to the state survey agency because he did not believe it was neglect. Interview on 11/12/24 at 3:38 P.M., Corporate RN #240 confirmed Resident #10 was a fall risk and on a toileting program and should have been checked on multiple times throughout the night. Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated 11/21/2016, revealed it is the facility's policy to investigate all alleged violation involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property. Additionally, the facility should immediately report all such allegations to the Administrator and to the state agency. The definition of neglect is the failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. This deficiency is an incidental finding discovered during the complaint investigation.