STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366374	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trueman Pointe Care Center	4660 Trueman Blvd Hilliard, OH 43026

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, medical record review, staff interview, and review of a facility policy, the facility failed to ensure residents were assessed for the use of a physical restraint. This affected two (#23 and #41) of two residents reviewed for physical restraints. The facility census was 63.Findings include:1. Review of the medical record for Resident #23 revealed an admission date of 12/23/22 with diagnoses including type two diabetes mellitus with diabetic chronic kidney disease, schizophrenia, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and bipolar disorder.Review of Resident #23's most recent comprehensive Minimum Data Set (MDS) assessment, dated 03/22/26, revealed Resident #23 had severely impaired cognition and had no impairments to bilateral upper and lower extremities. She required partial/moderate assistance with transfer and substantial/maximal assistance with ambulation.Review of the medical record for Resident #23 revealed a physician order dated 03/27/24 for a pressure sensor alarm (PSA) to the chair and an order dated 03/31/23 for a sensor pad alarm to the bed.Review of Resident #23's fall care plan dated 08/18/25 revealed Resident #23 was at risk for falls, had history of falls non-compliance, history of removing alarms and impaired cognition. Interventions included keeping the bed against wall to provide more space in the room, a mattress with raised perimeters, and a pressure sensor alarm to the bed and a pressure sensor alarm to the wheelchair.Further review of Resident #23's medical record revealed restraint-enabler decision tree assessments dated 11/26/25, 03/04/26, and 04/09/26. No assessment indicated the sensor alarms to the bed or chair were evaluated as a restraint.Review of the medical record for Resident #23 revealed no documentation to support the facility completed restraint assessments for the use of the alarms to the bed and chair.Observation on 05/19/26 at 2:40 P.M. and 05/20/26 at 9:30 A.M. and 11:39 A.M. revealed Resident #23 in a wheelchair with a PSA to the bed and wheelchair.Interview on 05/20/26 at 4:00 P.M., with the Administrator confirmed the facility had not completed restraint use assessments for Resident #23 for the use of alarms to bed and chair.2. Review of the medical record for Resident #41 revealed an admission date of 09/03/24 with diagnoses including type two diabetes mellitus with diabetic neuropathy, unspecified dementia, with other behavioral disturbance, schizoaffective disorder, bipolar disorder, anxiety disorder, unspecified convulsions, and nicotine dependence.Review of Resident #41's most recent MDS assessment, dated 04/07/26, revealed Resident #41 had moderate impaired cognition and had no impairments to bilateral upper and lower extremities. She required supervision/touching assistance with transfers and ambulation. The MDS assessment revealed she did not have any falls and a chair and bed alarm was identified on the assessment.Review of the medical record for Resident #41 revealed a physician order dated 02/23/25 for a PSA to the chair and bed.Review of Resident #41's fall care plan dated 10/14/24 revealed Resident #41 was at risk for falls, had dementia, impaired cognition, history of falls and non-compliance with interventions. Interventions included keeping the bed in the lowest position, encourage the resident to use a rollator rather than her cane with mobility, and ambulate with assistance and gait belt in place.Further review of Resident #41's medical record revealed restraint-enabler decision tree assessments dated 08/11/25, 11/11/25, and 03/31/26. No (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment indicated the sensor alarms to the bed or chair were evaluated as a restraint.Review of the medical record for Resident #41 revealed no documentation to support the facility completed restraint assessments for the use of the alarms to the bed and the chair.Observation on 05/17/26 at 10:00 A.M. and 3:00 P.M. revealed Resident #41 was in a wheelchair with a PSA to the bed and wheelchair.Interview on 05/20/26 at 4:00 P.M. with the Administrator confirmed the facility had not completed restraint use assessments for Resident #41 for the use of alarms to her bed and chair. The Administrator stated the alarms were discontinued on 05/18/26 due to a review and the resident had not had any falls.Review of facility policy titled, Restraint Use, dated 06/20/15, revealed the facility creates and maintains an environment that fosters minimal use of restraints. Alternatives to restraint use may include scheduled ambulation, diversional activities, scheduled exercise, use of a lounge chair and positioning devices such as pillows, cushions, bolsters, and lap belts or trays that the resident is able to self-release. A restraint assessment shall be used for initial and ongoing assessments.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to attempted non-pharmacological interventions for resident behaviors prior to administering as-needed psychotropic medications. This affected one (Resident #10) of five residents reviewed for antipsychotic medication administration. The facility census was 63.Findings include:Review of Resident #10's medical record revealed an admission date of 02/25/26 with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance; depression; unspecified psychosis not due to a substance or known physiological condition; and metabolic encephalopathy.Review of Resident #10's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she had severely impaired cognition.Review of Resident #10's plan of care dated 03/06/26 revealed she was at risk for adverse effects related to psychoactive medication use due to dementia with behaviors and depression. Interventions included to give medications as ordered, utilize as needed medications only after non-drug measures were ineffective, and report to the physician any negative outcomes associated with the use of psychoactive drug.Review of Resident #10's physician order dated 03/19/26 revealed an order for lorazepam (anti-anxiety medication) two (2) milligrams (mg) per milliliter (ml) oral concentrate with instructions to give 0.25 ml every one hour as needed for anxiety/restlessness.Review of Resident #10's medication administration record (MAR) for March 2026 revealed lorazepam was administered once on 03/14/26, 03/16/26, 03/21/26, 03/24/26, 03/26/26, and 03/29/26 and twice on 03/19/26 and 03/23/26.Review of Resident #10's MAR for April 2026 revealed lorazepam was administered once on 04/12/26, 04/13/26 and 04/19/26.Review of Resident #10's May 2026 MAR revealed lorazepam was administered once on 05/05/26 and 05/06/26.Further review of Resident #10's MARs for March through May 2026 revealed no non-pharmacological interventions were provided prior to administering as needed lorazepam on 03/14/26, 03/16/26, 03/19/26, 03/21/26, 03/23/26, 03/24/26, 03/26/26, 03/29/26, 04/12/26, 04/13/26, 04/19/26, 05/05/26, and 05/06/26.Interview and observation on 05/19/26 at 12:00 P.M. with Registered Nurse (RN) #216 revealed if a resident had an as needed psychotropic medication there was usually supplementary documentation to add for non-pharmacological interventions. At the time of the interview, an observation revealed a laminated sheet on top of the medication cart with the numbers correlating with the different interventions. Interview on 05/19/26 at 2:06 P.M. with the Director of Nursing (DON) verified no non-pharmacological interventions were provided prior to administering the as needed lorazepam to Resident #10 for the above mentioned dates in March, April, and May 2026. Interview on 05/20/26 at 11:30 A.M. with the Administrator revealed the behavior documentation and non-pharmacological interventions are documented by the certified nurse aides (CNAs) and not by the nurse administering the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and medical record review, the facility failed to ensure medications were properly stored. This affected one (#61) of one residents reviewed for medication storage. The facility census was 63.Findings include:Review of the medical record for Resident #61 revealed an admission date of 03/05/24 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, unspecified convulsions, unspecified glaucoma, and chronic pain syndrome.Review of Resident #61's care plan dated 03/26/24 revealed the resident was at risk for alteration in comfort related to chronic pain syndrome, arthritis, general pain, and chronic back pain. Interventions included to administer medications as ordered.Review of Resident #61's physician's orders revealed an order dated 04/21/26 for gabapentin (medication used for seizures or as an analgesic) 400 milligrams (mg) with instructions to give one pill by mouth every eight hours for neuropathy. Resident #61 had no orders to self-administer medications or for medications to be left at the bedside.Observation on 05/17/26 at 11:05 A.M. revealed one capsule in a cup on Resident #61's bedside table.Interview and interview on 05/17/26 at 11:05 A.M. with Licensed Practical Nurse (LPN) # 212 revealed she did not administer Resident #61 the medication in the morning indicating night shift nurses administer the medication, and stated the capsule appeared to be the resident's gabapentin. LPN #212 verified Resident #61 did not have an order for self-administration or for medications to be left at bedside.Interview on 05/22/26 at 11:30 A.M. with the Administrator revealed the facility did not have a policy for medication storage or medication administration.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure resident medical records were complete and accurate. This affected three (#2, #9, and #65) residents of 24 residents reviewed for documentation accuracy. The facility census was 63.Findings include:1. Review of the medical record for Resident #2 revealed an admission date of 04/02/24 with diagnoses including type one diabetes with diabetic neuropathy, acute chronic respiratory failure, and chronic kidney disease stage three. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had mild cognitive impairment, had adequate vision without devices, and was independently mobile using a manual wheelchair. Review of Resident #2's admitting diagnoses dated 04/03/24 included type one diabetes mellitus with diabetic neuropathy, unspecified (T1D).Review of multiple pulmonology progress notes listed T1D in Resident #2's active diagnoses.Review of multiple physician and nurse practitioner notes listed type two diabetes mellitus without complications (T2D) in Resident #2's active diagnoses. The diagnosis was not listed anywhere else in Resident #2's medical record.Interview on 05/19/26 at 2:06 P.M. with Director of Nursing (DON) #283 confirmed she did not know which diagnosis of diabetes was correct for Resident #2. At 4:13 P.M., DON #283 stated Resident #2 admitted with a diagnosis of T1D but endocrinology notes listed T2D. DON #283 confirmed T2D would be added to Resident #2's list of active diagnoses. DON #283 could not confirm which diagnosis was correct.Review of the medical record on 05/20/26 at 12:31 P.M. of Resident #2's active diagnoses revealed the addition of T2D. The diagnosis for T1D was still active and remained the primary diagnosis.Interview on 05/20/26 at 2:22 P.M. with DON #283 revealed she provided admission documentation time-stamped 03/27/24 included a diagnosis of T1D and an after visit summary dated 08/21/24 from an endocrinology appointment which included T2D with stage 3a chronic kidney disease, diabetic polyneuropathy, bilateral moderate non-proliferative retinopathy, and diabetic autonomic neuropathy. DON #283 was unable to verify which diagnosis was correct.2. Review of the medical record for Resident #9 revealed an admission date of 04/26/22 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, chronic pain syndrome, and chronic kidney disease stage one. Review of the annual MDS assessment dated [DATE] revealed Resident #9 was cognitively intact and was dependent on staff assistance for bathing, bed positioning, and mobility. Continued review of the MDS assessment revealed Resident #9 was at risk for skin breakdown, had no unhealed pressure ulcers, no unhealed venous or arterial ulcers, and no other skin conditions.Review of physician's orders date 09/17/25 revealed Resident #9 was to have a head-to-toe skin check completed weekly on the Saturday night shift.Review of the accident and incident log from 05/18/25 to 05/18/26 revealed Resident #9 a red area incident identified on 04/28/26 at 8:00 P.M.Review of the initial Skin Grid - Non-Pressure assessment dated [DATE] revealed a bruise to the outside of Resident #9's left leg two (2) centimeters (cm) long by 2 cm wide by 0.0 cm deep without odor or drainage.Review of the as needed Skin Grid - Non-Pressure assessment dated [DATE] revealed the wound had been recategorized as an abrasion. Further assessment of the wound revealed it was reported as healed on 05/19/26.Review of the treatment administration record (TAR) for May 2026 revealed Resident #9 had head-to-toe skin checks completed on 05/02/26, 05/09/26, and 05/16/26.Review of the progress note dated 04/29/26 (entered on 04/30/26) noted an area of concern to the outside of Resident #9's left leg. Assessment with the nurse practitioner identified the area as shearing. Further review of progress notes revealed no other notes related to this skin injury or of the findings of the weekly head to toe skin checks. Interview on 05/20/26 at 1:27 P.M. with DON #283 confirmed Resident #9 had orders for weekly head-to-toe skin assessments. DON #283 confirmed the nurse completing the skin checks should mark it as complete on the TAR and the nurse should document findings. DON #283 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the skin checks were marked as complete on the TAR and confirmed there were no notes in the chart reporting the findings from the assessments. Review of the policy titled, Skin Assessment, revised on 03/15/24, stated an assessment of a resident's alteration(s) of skin integrity shall be performed and recorded in the resident's medical record at least weekly.3. Review of the medical record for Resident #65 revealed an admission date of 02/11/26 with diagnoses including chronic respiratory failure with hypoxia, type two diabetes with diabetic neuropathy, and chronic peripheral venous insufficiency. Review of the MDS assessment date 03/25/26 revealed Resident #65 was cognitively intact and was dependent on staff assistance for bathing, toileting, and bed positioning. Further review of the MDS assessment revealed Resident #65 was at risk for skin breakdown and did not have any unhealed pressure ulcers, venous or arterial ulcers, or other skin conditions at the time of the assessment.Review of progress notes revealed Resident #65 had a hospitalization from 04/09/26 to 04/14/26 for altered mental status, urinary retention, and acute kidney injury with chronic kidney disease. While in the hospital, Resident #65 was evaluated by the wound care team for a pressure ulcer on his right heel. Resident #65 was found to have a stage three pressure ulcer (full-thickness skin loss) on the right heel originally identified on 01/05/26. A red area was also noted to Resident #65's sacrum and scabbed vascular ulcers to both lower legs. Review of the re-admission nursing note date 04/14/26 at 3:41 P.M. revealed Resident #65 returned to the facility from the hospital. A head-to-toe skin assessment was completed with findings including no open wounds but redness noted to the scrotum.Review of Resident #65's skilled progress note date 04/14/26 at 10:29 P.M. revealed a skin assessment was completed without any changes.Review of Resident #65's Skin Assessment Admission/readmission assessment completed on 04/14/26, completed by Licensed Practical Nurse (LPN) #236, revealed no pressure or non-pressure ulcers were present. Further review revealed identification of a pressure ulcer/injury on the mucosal membrane labeled Wound #1 and measuring one (1) cm long by 1 cm wide by 0.2 cm deep. There were no other descriptors of the wound and there were no other wounds or skin concerns noted in the assessment.Review of Resident #65's Skin Grid - Pressure assessment date 04/15/26 revealed Wound #1 had been updated to an unstageable pressure ulcer (obscured full-thickness skin and tissue loss) that was present on admission and measured 1 cm long by 1 cm wide by 0.2 cm deep.Review of the physician progress note dated 04/16/26 revealed Resident #65 had a stage three pressure ulcer and sacral contact dermatitis. Interview on 05/20/26 at 2:13 P.M. with LPN #236 confirmed she completed Resident #65's readmission assessment. LPN #236 confirmed Resident #65 had no skin issues present upon readmission on [DATE].Interview on 05/20/26 at 3:18 PM with Assistant Director of Nursing (ADON) #209 confirmed Resident #65's skin assessment completed upon readmission on [DATE] did not match the nursing progress notes of the same date.