STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366384	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Pointe Health Campus	600 West National Road Englewood, OH 45322

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366384	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Pointe Health Campus	600 West National Road Englewood, OH 45322

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, review of internal investigation log, and policy review, the facility failed to notify a resident's power-of-attorney (POA) following a significant medication error. This affected one (Resident #87) of four residents reviewed for notification after a change in condition. The facility census was 66.Findings include:Review of the closed medical record for Resident #87 revealed an admission date of 11/03/25 and discharged on 11/13/25. Diagnoses included fractured left femur, acute post hemorrhagic anemia, dementia, type two diabetes, hypertension, heart failure, and atherosclerotic heart disease. Review of the Incident log from 09/01/25 through 12/11/25 revealed a medication error on 11/11/25 at 6:55 A.M. involving Resident #87. Review of the Minimum Data Set (MDS) assessment for Resident #87 dated 11/10/25, revealed the resident was moderately cognitively impaired and dependent on staff for medication administration. Review of the blood pressure readings for Resident #87 on 11/11/25 revealed the residents blood pressure was 88/56 millimeters of mercury (mmHg) at 7:00 A.M, 80/50 mmHg at 7:15 A.M., 73/44 mmHg at 7:19 A.M., 88/51 mmHg at 7:38 A.M., 94/57 mmHg at 7:49 P.M., 97/59 mmHg at 8:04 A.M., 97/60 mmHg at 8:21 A.M., 102/60 mmHg at 8:37 A.M., 90/52 mmHg at 8:51 A.M., 98/59 mmHg at 9:15 A.M., 97/54 mmHg at 9:47 A.M., 90/52 mmHg at 10:05 A.M., 91/52 mmHg at 10:15 A.M, 79/38 mmHg at 11:07 A.M., 92/54 mmHg at 1:00 P.M., 88/56 mmHg at 1:45 P.M., 76/40 mmHg at 2:00 P.M., 75/48 mmHg at 2:15 P.M., 90/52 mmHg at 2:30 P.M. and 90/57 mmHg at 9:00 P.M.Review of the medication error investigation documents revealed on 11/11/25 at 6:55 A.M., Resident #87 was administered Resident #102's medication in error which included: Aspirin (anti-coagulant) EC 81 milligrams (mg), Coreg (slows heart rate) 25 mg, Clonidine (treats hypertension) 0.1 mg, Plavix (antiplatelet) 75 mg, Aricept (treats dementia caused by Alzheimer's disease) 5 mg, Losartan (treats hypertension) 100 mg, Namenda (treats dementia caused by Alzheimer's disease) 10 mg, Vitamin B complex tablet, and Hydralazine (treat hypertension) 50 mg. Review of the Investigation Timeline of Events revealed on 11/11/25 at 6:15 A.M., Resident #87 was administered medication that was due to be administered to Resident #102. At 6:40 A.M., Resident #87 alerted staff that he was feeling dizzy, and LPN #62 realized a medication error had occurred. At 6:42 A.M., Resident #87 was ordered to receive midodrine five mg, vital signs every 15 minutes and hold his normal medications. At 7:00 A.M., resident #87's blood pressure was still low, and Nurse Practitioner (NP) was contacted and ordered another midodrine 5 mg and a 500 milliliter (mL) bolus of normal saline via intravenous (IV) fluids. At 9: 20 A. M. the resident's daughter called the facility after the resident called her to tell her about the medication error. The Director of Nursing (DON) went to investigate what was going on with the resident. The DON established an IV, and the NP was notified of an IV line in place with fluids running. The last documented entry was at 4:00 P.M. which noted the resident was going to be monitored every hour through the night. Review of the progress note dated 11/11/25 at 7:08 A.M., revealed Resident #87 received the wrong medication and the resident had a hypotensive event. New orders were received for midodrine five mgs, monitor vital signs every 15 minutes until the resident's blood pressure stabilizes and place the resident in Trendelenburg position (head lower than feet to increase blood pressure). There was no documented evidence of the resident's POA being notified. Review of an occurrence note dated 11/11/25 at 1:17 P.M., revealed at 6:15 A.M., Resident #87 received the wrong medications. Resident #87 received the following medications Aspirin EC 81 mg, Coreg 25 mg, Clonidine 0.1 mg, Plavix 75 mg, Aricept 5 mg, Losartan 100 mg, Namenda 10 mg, Vitamin B complex tablet, and Hydralazine 50 mg. Review of the Interdisciplinary Team (IDT) note dated 11/11/25 at 1:21 P.M., revealed Resident #87 received the wrong medications during the morning medication administration. The on-call provider was contacted and ordered for all the resident's normal morning medications be held, give midodrine five mg one dose to help raise the resident's blood pressure and check vital signs every 15 minutes. The resident's blood pressure was still low, so the NP was notified and ordered another dose of midodrine five mg and start IV fluids. Resident #87 continued to complain of dizziness. Review of progress note dated 11/11/25 at 1:45 P.M., revealed Resident #87's was in up in a recliner and his blood pressure dropped. The resident was encouraged to get back in bed and elevate his legs. The NP was made aware and another as needed midodrine was administered for low blood pressure. There was no documented evidence that the resident's POA was contacted. Review of progress note dated 11/11/25 at 2:15 P.M., revealed Resident #87 continued to present with hypotension. The NP was made aware and another dose of midodrine was ordered to be given. There was no documented evidence that the resident's POA was contacted Review of November 2025 Medication Administration Record (MAR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366384	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Pointe Health Campus	600 West National Road Englewood, OH 45322

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366384	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Pointe Health Campus	600 West National Road Englewood, OH 45322

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 0760 Level of Harm - Actual harm Residents Affected - Few	THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on closed medical record review, review of facility investigation, review of facility's timeline of events, review of the incident log, staff interviews, and policy review, the facility failed to ensure residents were free from significant medication errors when one (Resident #87) who was moderately cognitively impaired and dependent on staff for medication administration, received another resident's (Resident #102) morning medications. This resulted in Actual Harm for Resident #87 when the resident was administered medications in error on 11/11/25 at 6:15 A.M. and at 6:40 A.M., the resident became acutely symptomatic with dizziness and low blood pressure. The on-call Nurse Practitioner (NP) was contacted and ordered for the resident to receive midodrine (medication to elevated blood pressure) five milligram (mg) and vital signs to be monitored every 15 minutes. At 7:00 A. M, the resident's blood pressure was still low (73/44 millimeters of mercury [mmHg]) and the NP ordered another dose of midodrine five mgs and a bolus of intravenous (IV) fluids. From 7:15 A.M. through 8:15 A.M, the resident's blood pressure remained low and at 9:20 A.M. and Resident #87 started receiving IV fluids. The resident had two additional low blood pressure readings requiring midodrine five mg at 2:37 P.M. and again at 9:00 P.M. This affected one (Resident #87) of the three residents reviewed for medication administration. The facility census was 66.Findings include: Review of the closed medical record for Resident #87 revealed an admission date of 11/03/25 and discharged on 11/13/25. Diagnoses included fractured left femur, acute post hemorrhagic anemia, dementia, type two diabetes, hypertension, heart failure, and atherosclerotic heart disease. Review of the Incident log from 09/01/25 through 12/11/25 revealed a medication error on 11/11/25 at 6:55 A.M. involving Resident #87. Review of the Minimum Data Set (MDS) assessment for Resident #87 dated 11/10/25, revealed the resident was moderately cognitively impaired and dependent on staff for medication administration. Review of the blood pressure readings for Resident #87 on 11/11/25 revealed the residents blood pressure was 88/56 mmHg at 7:00 A.M, 80/50 mmHg at 7:15 A.M., 73/44 mmHg at 7:19 A.M., 88/51 mmHg at 7:38 A.M., 94/57 mmHg at 7:49 P.M., 97/59 mmHg at 8:04 A.M., 97/60 mmHg at 8:21 A.M., 102/60 mmHg at 8:37 A.M., 90/52 mmHg at 8:51 A.M., 98/59 mmHg at 9:15 A.M., 97/54 mmHg at 9:47 A.M., 90/52 mmHg at 10:05 A.M., 91/52 mmHg at 10:15 A.M, 79/38 mmHg at 11:07 A.M., 92/54 mmHg at 1:00 P.M., 88/56 mmHg at 1:45 P.M., 76/40 mmHg at 2:00 P.M., 75/48 mmHg at 2:15 P.M., 90/52 mmHg at 2:30 P.M. and 90/57 mmHg at 9:00 P.M.Review of the medication error investigation documents revealed on 11/11/25 at 6:55 A.M., Resident #87 was administered Resident #102's medication in error which included: Aspirin EC 81 mg, Coreg (slows heart rate) 25 mg, Clonidine (treats hypertension) 0.1 mg, Plavix (antiplatelet) 75 mg, Aricept (treats dementia caused by Alzheimer's disease) 5 mg, Losartan (treats hypertension) 100 mg, Namenda (treats dementia caused by Alzheimer's disease) 10 mg, Vitamin B complex tablet, and Hydralazine (treat hypertension) 50 mg. Review of the Investigation Timeline of Events revealed on 11/11/25 at 6:15 A.M., Resident #87 was administered medication that was due to be administered to Resident #102. At 6:40 A.M., Resident #87 alerted staff that he was feeling dizzy, and LPN #62 realized a medication error had occurred. At 6:42 A.M., Resident #87 was ordered to receive midodrine five mg, vital signs every 15 minutes and hold his normal medications. At 7:00 A.M., resident #87's blood pressure was still low, and Nurse Practitioner (NP) was contacted and ordered another midodrine 5 mg and a 500 milliliter (mL) bolus of normal saline via intravenous (IV) fluids. At 9: 20 A.M. the resident's daughter called the facility after the resident called her to tell her about the medication error. An IV line was established, and the NP was notified of an IV line in place with fluids running. The last documented entry was at 4:00 P.M. which noted the resident was going to be monitored every hour through the night. Review of the progress note dated 11/11/25 at 7:08 A.M., revealed Resident #87 received the wrong medication and the resident had a hypotensive event. New orders were received for midodrine five mgs, monitor vital signs every 15 minutes until the resident's blood pressure stabilizes and place the resident in Trendelenburg position (head lower than feet to increase blood pressure). Review of an occurrence note dated 11/11/25 at 1:17 P.M., revealed at 6:15 A.M., Resident #87 received the wrong medications. Resident #87 received the following medications Aspirin EC 81 mg, Coreg 25 mg, Clonidine 0.1 mg, Plavix 75 mg, Aricept 5 mg, Losartan 100 mg, Namenda 10 mg, Vitamin B complex tablet, and Hydralazine 50 mg. Review of the Interdisciplinary Team (IDT) note dated 11/11/25 at 1:21 P.M., revealed Resident #87 received the wrong medications during the morning medication administration. The on-call provider was contacted and ordered