STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366440	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pointe Health & Rehab Center	402 Golf View Lane Highland Heights, OH 44143

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure resident care needs were adequately and timely met to decrease/prevent residents from contacting the local fire and police department for care including routine care and assistance. This affected eleven residents (#4, #11, #12, #13, #19, #42, #51, #54, #75, #79, and #98) of 83 residents who resided in the facility. Findings include: 1. Telephone interview on 05/30/24 at 9:48 A.M. with Detective #994 revealed ongoing concerns with calls coming into their police department from facility residents (from 01/10/24 through 05/30/24). He stated there were a lot of non-emergent calls from residents who wanted assistance from staff and staff were not answering the call lights timely. He stated this caused the residents to call 911 and request assistance unnecessarily. This included, but was not limited to at least 13 calls (not including calls for emergency squad or emergency medical services (EMS) involvement for hospitalization s: a. Review of Resident #4's medical record revealed the resident was admitted on [DATE] with diagnoses including dementia and other behavioral disturbances. Review of Resident #4's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #4's physician's orders revealed an order dated 07/28/23 to document pain every shift; and an order dated 07/28/23 for acetaminophen (Tylenol) 325 mg give two tablets by mouth every four hours as needed for pain (discontinued 01/16/24). During the interview, Detective #994 revealed an incident occurred on 01/10/24 when Resident #4 called the police because she had pain in her leg and no staff answered her call light. Detective #994 indicated the resident reported she put her call light on and no staff answered her call light to address the pain in her leg. Review of a police report dated 01/10/24 at 11:20 P.M. revealed Resident #4 stated she had stomach pain. The resident was subsequently transported to the hospital due to pain. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's medication administration record (MAR) and treatment administration record (TAR) from 01/01/24 to 01/31/24 revealed staff failed to identify or document any complaints of pain for the resident for the dayshift or nightshift during this time period. There was no evidence the resident was administered any Tylenol for pain on 01/10/24. Review of Resident #4's progress notes from 01/09/24 to 01/10/24 revealed no evidence staff documented or assessed the resident for complaints of pain, including stomach pain during this time period. Review of Resident #4's progress note dated 01/10/24 at 9:30 P.M. indicated the resident called EMS and went to the hospital per her request. Review of Resident #4's progress notes dated 01/10/24 at 11:35 P.M. indicated an ambulance arrived at the facility and stated Resident #4 had called EMS for abdominal pain. The resident was transported to the hospital. Review of Resident #4's progress note dated 01/11/24 at 1:02 P.M. authored by the Director of Nursing (DON) revealed a call was placed to Resident #4's daughter to inform her that the nurse stated she had called her twice with no answer obtained to let her know the resident called EMS twice on 01/10/24. The first time she asked for the police to come and the second time for EMS to transfer her to the hospital for stomach pain. Review of Resident #4's hospital Internal Medicine History and Physical Examination dated 01/11/24 revealed the [AGE] year-old female who had a known history of old stroke and dementia recently moved to Ohio from California. She stated the SNF mistreated and neglected her; and she was sent to the hospital. She was admitted for further management. Review of Resident #4's hospital emergency room documentation dated 01/11/24 revealed the resident stated the nursing home had mistreated and neglected her. Review of Resident #4's progress note dated 01/13/24 indicated the resident returned to the facility on [DATE] at 9:15 P.M. via a stretcher. The resident had been admitted to the hospital with a diagnosis of COVID-19. Review of Resident #4's hospital Discharge Summary form dated 01/13/24 revealed the resident was admitted for COVID-19. The hospital documentation did not include evidence of stomach pain or leg pain. An attempted interview on 06/03/24 at 10:24 A.M. with Resident #4 revealed the resident was confused. During the interview, the resident could not remember calling the police department for anything. Record review revealed no evidence of interventions or measures being implemented to ensure the resident's care needs were adequately and timely met to decrease/prevent the resident from contacting the local police and emergency medical services for care including routine care and assistance. Interview on 06/05/24 at 2:03 P.M. with the Administrator confirmed the facility was aware multiple residents, including Resident #4 had called police or fire for resident care. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident #98's medical record revealed the resident was admitted on [DATE] with diagnoses including diabetes, acute respiratory failure, and hemiplegia. Review of Resident #98's MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. During the interview with Detective #994, the detective stated an incident occurred on 02/27/24 when Resident #98 called the police to report she needed help. Review of the police report dated 02/27/24 at 2:06 A.M. revealed Resident #98 called, and her speech was slow and lethargic. She stated she did not have an emergency and she was ok. The facility was contacted and stated the nurse would check on the resident. Review of Resident #98's progress notes did not reveal evidence the resident was assessed on 02/27/24 following the call to the police department. Record review revealed Resident #98 was transferred to the hospital on 05/31/24 for a critically low hemoglobin. The family was updated on the resident's departure. The resident returned to the facility on [DATE] at 2:38 P.M. Interview on 06/11/24 at 8:12 A.M. with Resident #98's sister revealed the resident had been verbal and able to communicate in February 2024 but was currently in the hospital and non-verbal. During the interview, the resident's sister revealed she was unaware the resident had called the police in February 2024. Interview on 06/05/24 at 2:03 P.M. with the Administrator confirmed she was aware multiple residents called the police for care while residents in the facility including Resident #98. Record review revealed no evidence of interventions or measures being implemented to ensure the resident's care needs were adequately and timely met to decrease/prevent the resident from contacting the local police for assistance. c. Review of Resident #19's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, psychotic disturbance and anxiety. Review of Resident #19's care plans dated 03/23/23 revealed the resident had impaired cognitive function and impaired though processes related to dementia. Review of Resident #19's MDS 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem. During the interview with the detective, Detective #994 revealed an incident occurred on 03/05/24 when Resident #19 called police to report he could not get (staff) assistance when he had pushed his call light for help. The detective indicated a second incident occurred on 03/06/24 when Resident #19 called police because he could not get (staff) assistance when he had pushed his call light for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the police report dated 03/05/24 at 11:27 A.M. revealed Resident #19 stated he was unable to get help and needed a bed pan. The dispatcher called the facility and the phone line was busy. The dispatcher called the facility again and the resident was assisted. Review of the police report dated 03/06/24 at 10:28 A.M. revealed the resident was unable to get (staff) help and was vomiting. Staff were advised and checking with the manager if the resident should be sent to the hospital. A squad was requested due to a change in Resident #19's mental status and the resident was transported to the veteran's hospital. Review of Resident #19's progress note dated 03/07/24 at 1:11 P.M. revealed on 03/06/24 at 11:00 A.M. prior to transport to the hospital, the resident called the police and stated he could not stand up because of pain and the ceiling was spinning. The note indicated the resident was administered Tramadol (narcotic) for pain and stated he felt better immediately. The police arrived and asked the resident if he wanted to go to the hospital and he said yes and the ambulance company was called to transport the resident to the veteran's hospital. The resident was readmitted to the facility on [DATE] at 11:18 P.M. Interview on 06/05/24 at 2:03 P.M. with the Administrator confirmed she was aware multiple residents called the police and fire department for assistance including Resident #19. Record review revealed no evidence of interventions or measures being implemented to ensure the resident's care needs were adequately and timely met to decrease/prevent the resident from contacting the local police for assistance. d. Review of Resident #51's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, essential hypertension and insomnia. Review of Resident #51's MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. During the interview with the detective, Detective #994 revealed an incident occurred on 03/08/24 when Resident #51 called police to report no staff answered her call light for basic care. Interview on 06/06/24 at 9:46 A.M. with the Administrator and DON revealed Resident #51 had not called the police/fire on 03/08/24 but rather it was Resident #51's friend because the friend had not heard from the resident in a while. Review of the police report dated 03/08/24 at 8:44 A.M. revealed the caller requested a welfare check on Resident #51 who was at the facility. She stated the resident did not receive food and basic care and no one answered the resident's call light. The report revealed the police officer had observed a nurse exiting the resident's room following breakfast. The resident reported to the police officer that she did not have her oxygen or food. The DON was in the room with the police officer and verified the resident's oxygen was hooked up and working properly and the resident's food was sitting in front of her. The resident refused hospitalization and the police officer exited the facility. Interview on 06/06/24 at 10:01 A.M. with State tested Nursing Assistant (STNA) #837 revealed she remembered the police responding to Resident #51 but could not remember the exact date. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed no evidence of interventions or measures being implemented to ensure the resident's care needs were adequately and timely met to decrease/prevent the resident from contacting the local police for assistance. e. Review of Resident #79's medical record revealed the resident was admitted on [DATE] with diagnoses including cerebral infarction, diabetes and hyperlipidemia. Review of Resident #79's MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and had impairment on one side of the upper and lower extremities. During the interview with the detective, Detective #994 revealed an incident occurred on 03/29/24 when Resident #79 called the police to report a staff member abused him by putting their weight on the resident during care. Review of the police report dated 03/29/24 at 6:05 A.M. revealed Resident #79 had reported the nurse was abusing him by putting all her weight onto him when she leans into the bed. Record review revealed no evidence of interventions or measures being implemented to ensure the resident's care needs were adequately and timely met to decrease/prevent the resident from contacting the local police related to reports of abuse without staff knowledge. f. Review of Resident #42's medical record revealed the resident was admitted on [DATE] with diagnoses including spinal stenosis, diabetes, depression and anxiety disorder. Review of Resident #42's MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. During the interview, Detective #994 revealed an incident occurred on 04/14/24 when Resident #42 called the police to report his wallet had been stolen. There was no evidence the resident had first reported this to facility staff or that staff were investigating the incident. Review of Resident #42's witness statement authored by the Administrator on 04/08/24 at 5:00 P.M. revealed the resident indicated he last saw his wallet about a year ago at the movies. He stated he had always kept his wallet in his back pocket which had a picture of himself and $23.00. The resident denied credit cards were missing and denied he wanted to file and police report. Telephone interview on 06/11/24 at 8:05 A.M. with Resident #42's sister revealed the resident went to an appointment approximately two months ago and his wallet was missing. She stated the wallet contained a social security card, driver's license and bank card. When questioned, she stated no one had attempted to use the bank card but the facility could not find the wallet. She replaced the bank card. Interview on 06/12/24 at 8:56 A.M. with Resident #42 and the resident stated his wallet was missing. He could not report what was in the wallet or where he thought the wallet might have went. He stated his sister replaced his identification card and he was not missing any money. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed no evidence of interventions or measures being implemented to ensure the resident's care needs were adequately and timely met to decrease/prevent the resident from contacting the local police related to reports of theft/misappropriation without staff knowledge. g. Review of Resident #54's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, end stage renal disease and anemia. Review of Resident #54's MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. During the interview with the detective, Detective #994 revealed an incident occurred on 04/17/24 when Resident #54 called the police to report missing money. Review of Resident #54's witness statement dated 04/17/24 revealed the STNA overheard the resident having a conversation about money with his son and nephew and the son and nephew bought snacks in for the resident. No money was observed. Interview on 06/12/24 at 8:58 A.M. with Resident #54 who stated he put $20.00 in his drawer and reported it as stolen. He stated the facility reimbursed him for the $20.00 and then he found the money in the drawer stuck in the back of the drawer and the cabinet. h. During the interview with the detective, Detective #994 revealed the police were called on 04/18/24 by Resident #12's daughter to report an STNA intentionally pulled out the PEG tube. Review of Resident #12's nursing progress note dated 04/18/24 at 4:56 A.M. indicated the resident's needs could not be met in the facility at the time due to PEG tube issues. The PEG was pulled out by the resident. The resident was transferred to the emergency room . The resident had been prepared for transfer. The physician was notified and the resident was discharged at 11:00 P.M. with the face sheet, medication list and code status. i. Review of Resident #11's medical record revealed the resident was admitted on [DATE] with diagnoses including pain in the left leg, end stage renal disease with dependence on renal dialysis and paroxysmal atrial fibrillation. Review of Resident #11's MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. During the interview with the detective, Detective #994 revealed Resident #11 called the police and ambulance due to a nose bleeding and bleeding in his mouth . Review of Resident #11's MARS and TARS from 05/15/24 to 05/22/24 revealed the staff documented the resident's INR result on 05/20/24 on dayshift as not applicable (NA), on 05/20/24 on nightshift as 1.9; on 05/21/24 on dayshift as NA; on 05/20/24 on nightshift as 1.9; on 05/21/24 on dayshift as NA; on 05/21/24 on nightshift as 4.9; and on 05/22/24 on dayshift as 4.9. Review of Resident #11's Squad Report form dated 05/22/24 at 8:48 P.M. revealed the male who was bleeding from his mouth and nose. The resident stated he had been bleeding from his nose and gums all day. He stated he was on a blood thinner and was taken by stretcher to the hospital. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/05/24 at 2:03 P.M. with the Administrator confirmed she was aware multiple residents had called the police and fire department including Resident #11. Telephone interview on 06/10/24 at 6:31 P.M. with Resident #11 with the Administrator and RRN #979 present revealed on 05/22/24, he had reported to RN #812 between 2:00 P.M. and 3:00 P.M. that his nose and gums were bleeding. Resident #11 stated RN #812 assessed his mouth and stated that he must have broken one of his teeth which caused bleeding. She provided a saltwater rinse for the resident. Resident #11 stated between 6:30 P.M. and 6:34 P.M., RN #812 came in and told him that his PT/INR was 4.9 and that his Coumadin was to be held. He stated at that point, he called his friends in the fire department and decided to call EMS for transport to the hospital. He stated he was hospitalized from 05/22/24 to 06/03/24 to get his INR stabilized which included the administration of Vitamin K shots. The resident indicated the hospitalization would not have been necessary if the nursing staff had monitored his lab work closely and reported the abnormal labs to the physician before giving him his Coumadin. 2. Interview on 06/04/24 at 8:31 A.M. with Assistant Fire Department Chief #995 revealed the fire department had received multiple phone calls from residents at the facility. During the interview Chief #995 provided examples including on 05/20/24 when three different residents called their office to report care concerns. Calls were received from Resident #75 on 05/20/24 at 10:12 A.M. who stated she requested a breathing treatment, and the nurse did not bring it, Resident #13 on 05/20/24 at 11:37 A.M. who stated staff were not answering his call light and Resident #19 on 05/20/24 at 2:15 P.M. who needed to use the bathroom and no staff answered his call light. Interview on 06/05/24 at 1:20 P.M. with Regional Registered Nurse (RN) #979 revealed she believed the facility had investigated concerns with residents calling the police and fire departments and the facility attempted to determine the root cause of the resident complaints to the police and fire departments on 04/30/24. She revealed the facility tried to determine which staff members might be involved, what shift might be involved, days of the week involved and why the residents called the police for fire departments. However, Regional RN #979 revealed the facility could not determine a pattern. She stated the residents were interviewed, staff were educated, and a Quality Assurance and Performance Improvement (QAPI) plan was implemented to try to mitigate residents calling the police or fire unnecessarily. Interview on 06/05/24 at 2:03 P.M. with the Administrator she began employment at the facility on 05/20/24. The Administrator revealed she was currently attempting to schedule an appointment (call placed on 06/03/24) with the police and fire departments to introduce herself and to mitigate concerns. There was no evidence provided to confirm the appointments were scheduled for the meeting between the Administrator and the fire department or police department as of this date. An additional interview on 06/06/24 at 10:19 A.M. with the Administrator revealed the facility had been unable to specifically identify a root cause regarding the increase in resident phone calls directly to the police and fire departments for routine care and assistance. The Administrator revealed she believed the resident phone calls to the fire/police departments had decreased from 04/28/24 to the current date because of the facility added weekend supervisory position. The Administrator revealed the three resident phone calls to the fire department on 05/20/24 were on a Monday during the dayshift and she was present in the building as was the DON. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Telephone interview on 06/14/24 at 8:10 A.M. with Fire Department #995 indicated approximately two-thirds of their calls to the facility were from residents who said they could not obtain assistance. He stated from 06/01/24 to 06/14/24 multiple residents had called for assistance with care including on 06/09/24 at 2:47 P. M. Resident #53 stated no one would answer his light to take him to the bathroom. When the squad arrived, the nurse was taking the resident to the bathroom. Fire Department #995 indicated on 06/11/24 at 6:14 A.M. Resident #19 stated he had back pain and no one responded to his call light. When the squad had arrived, no nursing staff were aware the resident had called 911. Telephone interview on 06/14/24 at 8:18 A.M. with Fire Department #311 indicated he had responded to Resident #11's 911 call for assistance on 05/22/24 and their squad was on scene for 21 minutes. He stated he had observed Resident #11 with blood towels on the table, blood tissues, blood in cups and blood on the front of the resident. He stated three staff members were at the end of the hall laughing and talking on their cell phones while the squad team were in the building and no staff were in the room helping Resident #11. Further interview revealed he had asked the staff members for a Hoyer mechanical lift to get the resident on a cot for transport and no staff members brought the Hoyer mechanical lift or even talked to them and/or assessed the resident while the squad was in the room. He stated the room was in deplorable condition with bloody towels/tissues and the floor was sticky. Fire Department #311 indicated the entire 21 minutes the squad was in the building, not one staff member had come in to assess, monitor or assist Resident #11 in any way. Fire Department #311 indicated he asked for Resident #11's resident information and the nurse just handed him the form without talking to the squad about the resident or resident's care. He stated this was just one example and many residents from this facility called for assistance because the staff did not answer the call lights or respond to their requests for assistance. This deficiency represents non-compliance investigated under Complaint Number OH00154261, OH00153879 and OH00153809.

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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** 34297 Based on observation, record review, interview and policy review the facility failed to ensure Resident #40's non-pressure skin treatments were administered as ordered. This affected one (Resident #40) of three residents reviewed for skin alterations. Findings include: Review of Resident #40's medical record revealed the resident was admitted on [DATE] with diagnoses including osteomyelitis, diabetes, and anemia. Review of Resident #40's skin breakdown care plan, dated 02/08/24, revealed interventions including barrier cream/ointment after incontinence episodes as needed; small frequent shifts of body weight; turn and reposition as indicated; and elevate heels off the bed or use heel protectors. Review of Resident #40's Podiatry Note, authored by Podiatrist #982 and dated 04/01/24, revealed the resident's chief complaint was painful, dry skin on the bottoms of both feet for several months. The resident had painful, fissuring skin, plantar to the bilateral feet and diminished pedal pulses to the bilateral feet. The impression was xerosis (dry skin) to the bilateral plantar feet. The treatment included proper foot care and lac-hydrin 12% over the counter (OTC) cream (a hydrating cream) every morning to the bottom of both feet for six months. The podiatry visit was conducted in the facility during the morning of 04/01/24. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) from 04/01/24 through 05/23/24 revealed no documented evidence the lac-hydrin treatment to the resident's bilateral feet was completed per orders. Review of Resident #40's offsite Wound Care note, dated 04/01/24 at 1:00 P.M., revealed the resident was at risk for wounds to the right and left heels. Wound prevention interventions included padding and protecting the heels and free float from a pillow. Wound Care Treatments included to cleanse the left calcaneus with normal saline, apply skin prep to the peri-wound, apply an abdominal pad and kerlix every other day. Review of Resident #40's medication administration records (MARS) and treatment administration records (TARS) from 04/01/24 to 05/23/24 did not reveal evidence the wound intervention to the left calcaneus was completed as ordered. Review of Resident #40's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #40's Podiatry note, dated 05/13/24, revealed the resident had painful, dry skin on the bottom of both feet which was last assessed on 04/01/24. No new issues were identified and lac-hydrin continued. No pressure ulcers to the bilateral heels were identified. Review of Resident #40's physician orders revealed an order dated 05/13/24 for ammonium lactate cream 12% (lac-hydrin) topically to the bottom of both feet daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MARS and TARS from 05/13/24 to 05/28/24 revealed the ammonium lactate was administered to Resident #40's bilateral feet except on 05/20/24 and 05/22/24 which were documented as the resident refused. Interview on 05/23/24 at 1:17 P.M. with Regional Registered Nurse (RRN) #979 indicated the facility did not have Resident #40's outside wound clinic visit note when he came back from the office visit and were unaware of the resident's new orders for the left heel dressing changes. Telephone interview on 05/28/24 at 1:36 P.M. with Wound Nurse #978 (outside wound clinic) indicated Resident #40 was in their office on 04/01/24 and again on 05/23/24 (per the resident's request). Wound Nurse #978 stated the resident's wound care dressing on his bilateral feet, when he came in for his wound care appointment on 05/23/24, was the same dressing their office placed on 04/01/24. She stated the facility did not change the dressings to the resident's bilateral feet. She stated Resident #40 had reported it was the same dressings that were applied from 04/01/24. Interview on 05/28/24 at 1:46 P.M. with Resident #40 indicated he could not move anything from the waist down and the wound clinic had cleaned his bilateral feet on 04/01/24. Resident #40 stated staff were supposed to do a treatment to his left foot, but they had not completed the treatment from 04/01/24 to 05/23/24 (after his second wound clinic visit) or administered the lac-hydrin cream to his bilateral feet from 04/01/24 to 05/13/24. He denied he had mentioned the dressings needed to be changed to the staff members . Interview on 05/29/24 at 2:40 P.M. with Registered Nurse (RN) Unit Manager #922 confirmed Resident #40's MARS and TARS did not have evidence the wound care treatment to the left calcaneus was completed from 04/01/24 to 05/23/24 or the lac-hydrin to the bilateral feet was completed from 04/01/24 to 05/13/24. Observations on 05/29/24 at 2:50 P.M. with facility Wound Nurse Practitioner (NP) #983 of Resident #40's wound care did not reveal any concerns. The resident had an air mattress and green prafo boots in place at the time of the observation. He was ordered to turn and reposition every two hours and offload heels. She stated the resident always had his prafo soft pressure prevention boots in place and he was non-compliant with care including turning and repositioning and showers. She stated the resident's bilateral feet wounds were vascular in nature (non-pressure) due to the resident's declining condition and extremely dry skin. Review of Wound NP #983's facility Wound Evaluation form dated 05/29/24 revealed the resident had a history of wounds to the bilateral heels that have remained intact with pink scar tissue. Preventative measures had been in place since the resident was initially evaluated in 11/22. The offloading boots were always worn and removed for hygiene care. The visit to the wound center on 05/23/24 revealed some concerns regarding the dressing from the original follow-up on 04/01/24 and had not been changed. Per podiatry documentation from both 04/01/24 and 05/13/24, the feet were examined and the dry, scaly area on the plantar aspect of the feet remained. The resident remained non-compliant with showers. (continued on next page)

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	366440	A. Building B. Wing	06/14/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 05/30/24 at 8:57 A.M. with outside Wound Clinic RN #984 revealed Resident #40 reported his dressing on his bilateral feet were the same ones as 04/01/24. She stated the dressings looked old but were not dated or timed. She denied the resident had skin impairment to the right or left heels during the wound care visit on 04/01/24. Outside Wound Clinic RN #984 confirmed Resident #40 did not have pressure on either heel on 04/01/24 and had a very small open area on both heels on 05/23/24. Telephone interview on 05/30/24 at 9:32 A.M. with NP #985 revealed she assessed Resident #40 on 05/23/24 at the wound clinic and he had a lot of dry skin and poor hygiene. She felt all the new wounds identified on 05/23/24 were superficial and from cleaning the dry skin from the resident. She stated she was aware the resident was non-compliant with care including bathing and felt that was the major concern regarding the resident's wounds. NP #984 denied Resident #40's bilateral heel wounds were pressure and she felt the wounds were vascular in nature. She stated she felt these wound occurred when the outside wound clinic staff cleaned his legs and feet and peeled off all the dead skin. Review of Resident #40's outside Wound note dated 05/30/24 revealed the resident had a history of non-pressure wounds to the other part of left foot; chronic non-pressure ulcer of left heel and midfoot, right great toe, left great toe, chronic non pressure ulcer of right heel and midfoot, necrotizing vasculopathy, chronic multifocal osteomyelitis right humerus and sacrum. Review of the wound care policy revised 09/18/20 indicated wounds identified would be assessed initially and at least weekly thereafter, until healed. This deficiency represents non-compliance investigated under Master Complaint Number OH00154752 and Complaint Numbers OH00154253, OH00154260 and OH00153809.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on closed record review, hospital record review, policy review and interview, the facility failed to ensure Resident #11 was administered pain medications as ordered. This affected one (Resident #11) of four residents reviewed for medication administration. Findings include: Review of Resident #11's hospital documentation revealed the resident had a left foot and ankle charcot neuroarthropathy with status post left ankle fusion and application for external fixator on 05/02/24. Further review of Resident #11's hospital documentation revealed discharge orders dated 05/15/24 for oxycodone (narcotic pain medication) extended release (ER) 15 mg (milligram)12-hour tablet take one tablet by mouth every 12 hours for fourteen days; and hydromorphone (dilaudid narcotic pain tablet) 4 mg tablet take one tablet by mouth every four as needed for pain up to seven days. Review of Resident #11's closed medical record revealed the resident was admitted on [DATE] with diagnoses including charcot neuropathy status post left ankle fusion and application of external fixator on 05/02/24, pain in the left leg, end stage renal disease with dependence on renal dialysis and paroxysmal atrial fibrillation. Review of Resident #11's Baseline Care Plan dated 05/15/24 revealed the resident would be monitored for adverse reactions to high-risk medications. Review of Resident #11's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition, was frequently in pain and received non-medication interventions for pain. Review of Resident #11's physician orders revealed an order dated 05/15/24 to monitor the pain level every shift; an order dated 05/15/24 for hydromorphone 4 mg every four hours for seven days (stop date 05/22/24); an order dated 05/15/24 (discontinued 05/21/24) for oxycodone ER 15 mg administer one tablet orally every twelve hours as needed for pain; and an order dated 05/21/24 to administer oxycodone ER 15 mg one tablet every shift. Review of Resident #11's medication administration records (MARS) from 05/15/24 to 05/22/24 revealed the resident was administered the hydromorphone narcotic pain medication on 05/15/24 at 11:35 P.M., 05/16/24 at 8:29 A.M., 05/17/24 at 9:49 A.M. and 05/18/24 at 3:48 P.M. Review of Resident #11's MARS from 05/15/24 to 05/22/24 revealed the resident was administered the oxycodone ER narcotic pain mediation on 05/16/24 at 5:02 A.M., 05/16/24 at 6:13 P.M., 0517/24 at 10:28 P. M., 05/18/24 at 9:26 P.M., 05/18/24 at 1:21 P.M., 05/20/24 at 5:03 A.M., 05/21/24 at 8:54 A.M. No concerns were identified. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's medication administration records (MARS) and treatment administration records (TARS) from 05/15/24 to 05/22/24 revealed the resident's pain was monitored every shift with a pain level of 8 (one being least and 10 being the worst) on 05/15/24 during the nightshift, an 8 on 05/16/24 during the dayshift, a zero on 05/16/24 during the nightshift, a zero on 05/17/24 during the dayshift, a zero on 05/17/24 during the nightshift, a five on 05/18/24 during the dayshift, a 4 on 05/17/24 during the nightshift, a zero on 05/19/24 during the dayshift, a zero on 05/19/24 during the nightshift, a zero on 05/20/24 during the dayshift, a zero on 05/20/24 during the nightshift, a zero on 05/21/24 during the dayshift, a four on 05/21/24 during the nightshift and a zero on 05/22/24 during the dayshift. Review of Resident #11's progress note authored by Certified Nurse Practitioner (CNP) #980 with a service date of 05/21/24 at 12:00 P.M. indicated the resident had a history non-pressure chronic ulcer of the unspecified heel and midfoot with bone involvement without evidence of necrosis . The oxycodone narcotic was transcribed incorrectly and corrected with nursing for every 12 hours. Telephone interview on 06/04/24 at 6:42 P.M. with CNP #980 stated she assessed Resident #11 on 05/21/24 and the resident reported his pain was not as controlled as it had been, and they were not administering his narcotic pain medications as ordered. NP #980 revealed she reviewed the medical record and determined the staff had transcribed the hospital discharge orders incorrectly and did not administer the oxycodone ER as ordered. She stated Resident #11 was to receive the oxycodone ER scheduled with hydromorphone for breakthrough pain. NP #980 indicated this was corrected on 05/21/24 and he went out to the hospital on 05/22/24. Telephone interview on 06/10/24 at 6:31 P.M. with Resident #11 revealed the nursing staff did not administer his pain medications as ordered for the pain in his left leg. He stated they messed up his pain regimen. Review of the Medication Admin policy revised 05/01/10 revealed the facility should ensure authorized personnel, as determined by applicable law, administer medications according to times of administration and determined by the facility's pharmacy committee and/or physician prescriber. The facility was unable to provide a Pain Management Policy. This deficiency represents non-compliance investigated under Complaint Numbers OH00154752, OH00154253, OH00153950 and OH00153809.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34297 Based on record review and interview, the facility failed to ensure sufficient nursing staff with the appropriate competencies and skills sets were on duty and provided the necessary access to the resident's electronic health record to ensure medications were administered in a timely manner. This affected 15 residents (#5, #12, #29, #49, #53, #54, #55, #58, #59, #64, #67, #71, #72, #78 and #84's) assigned to Licensed Practical Nurse (LPN) #401 on 06/04/24. The facility census was 83. Findings include: Review of the staffing schedule for 06/04/24 for the 7:00 P.M. to 06/05/24 7:00 A.M. shift revealed four licensed nurses were scheduled for 83 total residents. LPN #897 was noted to report off for the shift on 06/04/24 at 6:30 P.M. The facility contacted a staffing agency, and LPN #401 reported to work (to replace LPN #897), arriving to the facility at 7:00 P.M. The LPN was assigned to provide care for twenty residents including Residents #3, #4, #5, #12, #29, #49, #53, #54, #55, #58, #59, #64, #66, #67, #68, #71, #72, #73, #78 and #84 on the 100/200 split. The 100/200 split included ten residents, Resident #4, #29, #49, #59, #64, #66, #67, #71 and #73 with diagnosis of dementia/cognitive impairment. Review of resident records on the 100/200 unit revealed 19 residents reside on the 100/200 split including Residents #3, #4, #5, #12, #29, #49, #53, #54, #55, #58, #59, #64, #66, #67, #68, #71, #72, #78 and #84's. Further review of Residents #3, #4, #5, #12, #29, #49, #53, #54, #55, #58, #59, #64, #66, #67, #68, #71, #72, #78 and #84's medical records, medication administration records (MARS) and treatment administration records (TARS) revealed Residents #4 and #66 were not scheduled nighttime medications and Residents #3 and #68 had received the medications as ordered on 06/04/24. Telephone interview on 06/10/24 at 12:27 P.M. with LPN #401 confirmed she worked on 06/04/24 during the 7:00 P.M. to 7:00 A.M. shift on the 100/200 unit split with approximately 19 residents. During the interview the LPN revealed she did not receive login information timely for the facility electronic health records (EHR) and was unable to start her medication administration pass until around 10:00 P.M. (for medications scheduled to be administered between 7:00 P.M. and 11:00 P.M. The LPN verified the medications were administered on this date due to the staffing issue and lack of access to the facility EHR system. a. Review of Resident #5's medical record revealed the resident had physician orders for medications scheduled to be administered between 7:00 P.M. and 11:00 P.M. which included Atorvastatin (for high cholesterol) and Travoprost eye drops. Record review revealed the medications were administered on 06/05/24 at 2:10 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident #12's medical record revealed the resident had physician orders for medications including Atorvastatin, Buspirone (antianxiety), Cyclobenaprine (treats muscle spasms), Docusate Sodium, Hydralazine, Hydroxyzine (antianxiety), Lactulose, Levetiracetam (for seizures), Paroxetine (antidepressant) and a stool softener which were scheduled to be administered between 7:00 P.M. and 11:00 P.M. The medications were administered on 06/05/24 at 2:16 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system. Interview on 05/28/24 at 8:23 A.M. with Resident #12's family member indicated the resident was not provided timely care during the nightshift and she felt there was not enough staff in the building to provide care to the resident. c. Review of Resident #29's medical record revealed the resident had physician order for the anti-coagulant medication, Eliquis scheduled to be administered from 7:00 P.M. to 11:00 P.M. The medication was administered on 06/05/24 at 2:18 A.M. The medication was not administered as ordered due to LPN #401 not having proper access to the facility record system. d. Review of Resident #49's medical record revealed the resident had physician orders for medications scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Atorvastatin and Remeron. The medications were administered on 06/05/24 at 2:24 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system. e. Review of Resident #53's medical record revealed the resident had physician orders for medications scheduled to be administered between 7:00 P.M. to 11:00 P.M. which included an albuterol inhaler, Atorvastatin, Divalproex (anticonvulsant), Pepcid, Hydroxyzine, Levetiracetam and Methocarbamol (treats muscle spasms). The medications were administered on 06/05/24 at 2:26 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system . f. Review of Resident #54's medical record revealed the resident had physician orders for medications scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Baclofen, Eliquis, Hydralazine (high blood pressure medication) Lantus insulin and Metoprolol. The medications were not administered as ordered and scheduled between 7:00 P.M. and 11:00 P.M. due to the LPN not having proper access to the facility record system. g. Interview on 06/12/24 at 8:50 A.M. with Resident #55 revealed there was not enough staff and staff kept administering her medications late. Review of Resident #55's medical record revealed the resident had physician orders for medications scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Atorvastatin, Baclofen, Buspirone, Divalproex, Eliquis, Iron, Melatonin, Metoprolol, Symbicort inhaler and stool softener. The medications were administered on 06/05/24 at 2:29 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system. h. Review of Resident #58's medical record revealed the resident had physician orders for medications scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Atorvastatin, Iron, Gabapentin, Hydralazine, Lantus insulin, Melatonin and Oxycodone. The medications were administered on 06/05/24 at 2:32 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Review of Resident #59's medical record revealed the resident had physician orders for medications scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Atorvastatin, Lantaprost eye drops and Melatonin. The medications were administered on 06/05/24 at 2:35 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system. j. Review of Resident #64's medical record revealed the resident had physician orders for medications scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Tylenol, Mirtazapine and Trazodone. The medications were administered on 06/05/24 at 2:34 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system. k. Review of Resident #67's medical record revealed the resident had physician orders for medications scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Tylenol, Coreg (anti-hypertensive) and eye drops. The medications were administered on 06/05/24 at 2:36 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system. l. Review of Resident #71's medical record revealed the resident had physician orders for medications scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Baclofen, Keppra (an anti-convulsant), Lactulose, Norvasc, Miralax, Propranolol (an antihypertensive), Senna and Vimpat (anti-epileptic). The medications were administered on 06/05/24 at 2:40 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system. Telephone interview on 05/28/24 at 11:49 A.M. with Resident #71's power-of-attorney (POA) confirmed she was in the building on 06/04/24 and the resident had received the nighttime medications after midnight. She stated she believed this was because of lack of staffing in the building. m. Review of Resident #72's medical record revealed the resident had physician orders for medications scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Aricept, Lantaprost eye drops and Lantus insulin. The medications were administered on 06/05/24 at 2:42 A.M. The medications were not administered as ordered due to LPN #401 not having proper access to the facility record system . n. Review of Resident #78's medical record revealed the resident had a physician order for medication scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Miralax. The medication was administered on 06/05/24 at 2:43 A.M. The medication was not administered as ordered due to LPN #401 not having proper access to the facility record system. o. Review of Resident #84's medical record revealed the resident had a physician order for medication scheduled to be administered from 7:00 P.M. to 11:00 P.M. which included Metoprolol. The medication was administered on 06/05/24 at 2:45 A.M. The medication was not administered as ordered due to LPN #401 not having proper access to the facility record system. Interview on 05/23/24 at 9:34 A.M. with Resident #26 indicated the staff did not check on her during the nightshift. She felt there were not enough staff to provide timely resident care. Telephone interview on 05/28/24 at 9:27 A.M. with Resident #26's power-of-attorney revealed the resident was not checked on during the nightshift and she felt staffing was an issue. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/12/24 at 9:21 A.M. with RN Supervisor #922 confirmed LPN #401 did not administer Resident #5, #12, #29, #49, #53, #54, #55, #58, #59, #64, #67, #71, #72, #78 and #84's medications as ordered on 06/04/24 because the nurse did not have computer access to administer these medications as ordered. Telephone interview on 06/14/24 at 8:10 A.M. with Assistant Fire Department #995 revealed residents called their department on multiple dates due to the staff not answering their call lights to provide care. Telephone interview on 06/14/24 at 8:18 A.M. with Fire Department #311 indicated he felt the facility was short staffed. He stated he had responded to multiple calls at the facility. He stated on 05/22/24 he went to the facility to respond to Resident #11's call for assistance and he had observed three staff members at the end of the hall laughing and talking on their telephones for the entire 21 minutes he was in the building. He stated not one staff member was observed to come into Resident #11's room while their team was there and assist the resident or ask the resident if he needed anything. Additionally, he stated his team was called to the building on multiple occasions to respond to resident's calling and asking for assistance from their department and when the team arrived in the facility and walked down the hall, multiple residents would see their team and yell out for assistance because the staff members were not answering their call lights and responding to the resident requests. Review of the undated staffing policy named Policy revealed each nursing home shall have sufficient direct care staff on each shift to meet the needs of the residents in an appropriate and timely manner and have the following individuals provide a minimum of two and one-half hours of direct care and services per day including nurse aides, RN's and LPNs. Review of the Medication Administration policy revised 05/01/24 revealed the facility should ensure authorized personnel, as determined by applicable law, administer medications according to the times of administration as determined by the facility's pharmacy committee and/or physician prescriber. This deficiency represents non-compliance investigated under Master Complaint Number OH00154752 and Complaint Numbers OH00154261, OH00154253, OH00153953, OH00153950, OH00153879 and OH00153809.

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on closed medical record review, hospital record review, review of a police and Emergency Medical Service (EMS) report, social media review, review of the Food and Drug Administration online medication information, policy review and interviews, the facility failed to timely respond and take appropriate action (e.g. , suspending administration of an anticoagulant) in regard to an elevated International Normalized Ratio (INR) for Resident #11, who was receiving Warfarin (Coumadin) for atrial fibrillation. This resulted in Immediate Jeopardy and the potential for serious harm on 05/20/24 when the resident's INR, per laboratory testing, was abnormally high at 4.9 and staff failed to notify the physician or stop the administration of the medication, Coumadin. Staff continued to administer Coumadin 7.5 milligrams on 05/20/24 and 05/21/24 despite the high laboratory value, indicating the resident's blood was too thin and requiring a greater length of time to form a blood clot. On 05/22/24, Resident #11 reported he was having nose and gum bleeding. The resident subsequently called 911 for transport to the hospital for medical care. Upon Emergency Medical Service (EMS) arrival, EMS staff noted a large amount of bloody paper towels on the resident's bedside table. Upon arrival at the hospital (on 05/22/24 at 9:25 P.M.) the resident's chief complaint included nose and gum bleeding. Hospital emergency laboratory testing revealed the resident's PT was elevated at 63.4 seconds (reference range 9.7-13.0) and the INR was abnormally high at 7.2 (therapeutic range 2-3 with an anticoagulant planned INR of 2.5). The resident required treatment with Vitamin K (used to counteract the anticoagulant medication) intravenously and was hospitalized until 06/03/24 for ongoing care and treatment. This affected one resident (Resident #11) of five residents reviewed for Coumadin use. On 06/12/24 at 10:25 A.M. the Administrator, Director of Nursing (DON) and Regional Registered Nurse (RRN) #979 were notified Immediate Jeopardy began on 05/20/24 when the facility failed to monitor physician ordered laboratory results (INR) to ensure Resident #11's Coumadin was effective (by not allowing the resident's blood to clot too quickly or too slowly) and failed to notify the physician of an abnormally elevated INR result (4.9) to suspend the administration of Resident #11's Coumadin. Nursing staff continued to administer the Coumadin despite the elevated INR results placing the resident at significant risk for bleeding/continued blood loss. Resident #11 contacted EMS for emergent transport to the hospital for evaluation, received intravenous Vitamin K to counteract the effects of Coumadin and was subsequently admitted to the hospital for ongoing care and treatment. The Immediate Jeopardy was removed on 05/23/24 when the facility implemented the following corrective actions: Resident #11 was discharged to the hospital on 5/22/24 at 9:00 P.M. On 05/23/24 at 11:00 A.M. the Director of Nursing (DON), Assistant Director of Nursing (ADON) #918 and Registered Nurse (RN) Unit Manager (UM) #922 reviewed Resident #11's medical record, medication administration record (MAR), progress notes and laboratory results (labs) to identify the root cause related to the bleeding incident on 05/22/24. The facility identified the root cause as nursing staff including Licensed Practical Nurse (LPN) #883 and LPN #963 failed to check Resident #11's PT/INR level prior to administering Coumadin 7.5 mg to Resident #11 on 05/20/24 and 05/22/24 and failed to notify medical doctor (MD)/Certified Nurse Practitioner (CNP) #980 of Resident #11's abnormal INR level in a timely manner. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/23/24 at 11:30 A.M. the DON, ADON #918, RN UM #922 and Regional RN (RRN) #979 completed an in house audit and confirmed four residents resided in the facility who receive Coumadin including Residents #38, #44 #76 and #82. Resident records for Residents #38, #44, #76 and #82 were reviewed which included the lab reports, medication administration records (MARs), progress notes and care plans to ensure that abnormal labs were reported to Nurse Practitioner (NP) #980 in a timely manner and that Coumadin was not administered to residents with a PT/INR greater than 3.0, without negative findings. T On 05/23/24 at 12:00 P.M. the DON, RN ADON #918, RN UM #922 and Regional RN #979 completed assessments/skin checks on Residents #38, #44, #76 and #82 (receiving Coumadin) to ensure the residents did not have signs of bleeding or bruising. On 05/23/24 at 1:00 P.M. RRN #979 completed competencies, in person with return demonstration, with the DON, ADON #918 and RN UM #922 to review PT/INR blood work prior to administering Coumadin and education was provided on reporting of abnormal labs to CNP #980 of the specific resident by the end of the shift. On 05/23/24 at 2:00 P.M., LPN #883 and LPN #963 (two nurses who were out of compliance related to the Immediate Jeopardy) were educated (in person) by the DON, with return demonstration, on checking residents PT/INR blood work prior to administering Coumadin and on reporting of abnormal labs to CNP #980 of the specific Resident by end of shift. On 05/23/24 beginning at 2:00 P.M. through 4:35 P.M., RRN #979 completed an audit of the lab work for Residents #38, #44, #76 and #82. NP #980 was notified of all lab results. The audit revealed Resident #76's PT/INR lab work dated 05/23/24 had an INR of 3.6 and the NP was notified on 05/23/24 and ordered to hold the Coumadin dose and repeat the INR on 05/24/24. On 05/23/24 at 2:15 P.M., the DON, ADON #918 and RN UM #922 completed competencies with LPN #883 and LPN #963, in person with return demonstration, on checking residents PT/INR prior to giving Coumadin and to ensure that the lab results are reported to CNP #980 of the specific Resident by end of shift. On 05/23/24 at 3:30 P.M. the facility held an emergency Quality Assurance Performance Improvement (QAPI) meeting. The QAPI meeting was held to review the root cause, reviewed the facility abatement plan due to the nurses administering Coumadin prior to checking Resident #11's PT/INR labs and not notifying NP #980 responsible for Resident #11's care, by the end of the shift. Medical Director #669, the Administrator, the DON, ADON #918, Environmental Services Director (ESD) #805, Pharmacist #1012 (participated over the phone), RRN #979, Social Services Designee (SSD) #931, Activity Director (AD) #930 and Rehab Director #1024 participated in the QAPI meeting. On 05/23/24 at 6:00 P.M. the DON developed and implemented a PT/INR Coumadin flow sheet. ADON #918 and RN UM #922 were educated on the form, how to implement the form, when to use the form and what to do for abnormalities identified on the form. Both nurses would print Coumadin lab reports five days a week at Clinical Morning Meetings to review any changes in orders due to any abnormal lab results & to ensure the CNP of the specific resident was notified of the results by the end of the reporting shift. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/23/24 at 6:30 P.M. the Coumadin flow sheet was implemented by ADON #918 and RN UM #922. The form would be completed each time a blood draw was ordered with results received for each resident on Coumadin. The abnormal results would be reported to CNP #980 of the specific resident by end of the reporting shift. On 05/23/24 at 11:45 P.M. the DON, ADON #918 and RN UM #922 completed education in person and via phone to all 17 staff LPNs and all six staff RNs on checking residents' PT/INR results prior to giving Coumadin and to ensure that the lab results were reported to NP #980 of the specific resident by the end of the reporting shift. In addition, all 37 staff State tested Nursing Assistants (STNA) were educated on observing for abnormal effects of Coumadin including bleeding, bruising and black tarry stools and reporting abnormalities to the nurse. The facility also used agency staffing including four agency RN's (to be educated from 05/23/24 to 06/04/24), eight agency LPN's (to be educated from 05/27/24 to 06/11/24) and five agency STNA's (to be educated from 05/24/24 to 06/09/24) who work as needed in the facility. RRN #979 confirmed the agency staff members were educated over the phone and would not work in the facility from 05/23/24 to 06/14/24, unless they had received the education prior to their next scheduled shift. The facility indicated all new hires would receive the education during orientation. On 05/23/24 at 11:45 P.M. the DON, ADON #918 and RN UM #922 completed competencies to ensure 17 LPNs and six RNs were checking residents PT/INR prior to giving Coumadin and to ensure that the lab results are reported to NP #980 in a timely manner. To ensure ongoing compliance, the DON/ADON/UM/Designee would audit PT/INR lab results and timely notification of the residents' NP four times a week for three weeks. The audits would be completed beginning on 06/06/24 and the facility would then continue a monthly audit for the next two months, during clinical morning meetings, for verification the PT/INR results were reviewed and reported to the residents' NP as needed. The results of the audits would be forwarded to the facility QAPI committee for additional review and recommendations. Although the Immediate Jeopardy was removed on 05/23/24, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #11's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including pain in the left leg, end stage renal disease with dependence on renal dialysis and paroxysmal atrial fibrillation (intermittent irregular heartbeat in the upper chambers of the heart). The resident was transferred to the hospital on 05/22/24 and did not return to the facility. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #11's baseline care plan dated 05/15/24 revealed the resident would be monitored for abnormal bleeding due to anticoagulation treatment. The care plan revealed the resident would receive anticoagulant therapy as ordered; would be observed for any signs and symptoms of abnormal bleeding including bruising, tarry stools, nose bleeds, bleeding gums and/or hemorrhage; would receive education on the risks and benefits of anticoagulant therapy if needed; be monitored as ordered for lab tests to monitor coagulation factors and have any abnormal findings reported to the provider including the physician, nurse practitioner or physician assistant. Review of Resident #11's physician orders revealed an order dated 05/16/24 for Warfarin (Coumadin) 7.5 mg one tablet to be administered orally once daily (scheduled to be administered between 7:00 P.M. to 11:00 P.M.); and an order dated 05/18/24 to obtain a Prothrombin Time (PT) and International Normalized Ratio (INR) (The INR is a standardized number that measures how long it takes blood to clot. It's calculated using the results of the PT test, which measures how quickly the liquid portion of a person's blood clots. The INR is used to monitor people who take blood thinners, also known as anticoagulants, like Coumadin, to help ensure the medication is working properly. The higher the INR, the longer it takes the person's blood to clot) two times per week on Monday and Thursday. Further review of the medical record revealed no specific parameters for changes to the resident's Coumadin dosage or parameters for contacting/notifying the physician related to the INR results. Record review (also dated 05/16/24) revealed nursing staff were to initial for anticoagulant monitoring every shift (ensuring the PT/INR results were reviewed/available and the daily dose of Coumadin was available in the medication cart for the evening/night administration). This was documented on the medication administration record for the respective dates and shifts during the resident's stay. Review of Resident #11's laboratory testing revealed the resident's bloodwork was collected on (Thursday) 05/16/24 at 7:10 A.M. and reported on 05/16/24 at 3:57 P.M. The results of the PT and INR dated Thursday, 05/16/24 revealed the PT was 19.3 seconds and the resident's INR was 1.9. There was no evidence of any changes to the Coumadin order at this time. Review of Resident #11's laboratory testing revealed a PT/INR was drawn on (Monday) 05/20/24 at 2:50 P. M. and reported on 05/20/24 at 5:47 P.M. The resident's PT was 47.1 seconds (elevated), and the resident's INR was 4.9 (elevated). This laboratory form indicated the standard anticoagulant was 2.0 to 3.0 range for the INR and aggressive anticoagulant treatment was 2.5 to 3.5 INR range. Record review revealed no evidence the physician, nurse practitioner or physician assistant were notified of this abnormally high laboratory test result on 05/20/24. Review of Resident #11's medication administration records (MAR) and treatment administration records (TAR) from 05/20/24 to 05/22/24 revealed on 05/20/24 during the dayshift, Licensed Practical Nurse (LPN) #935 documented on the MAR, the INR was not applicable (NA); on 05/20/24 during the nightshift, LPN #883 documented on the MAR that the INR was 1.9 (however, these were the INR results obtained in 05/16/24). On 05/21/24 during the dayshift, LPN #935 documented the INR on the MAR as NA; On 05/21/24 during the nightshift, LPN #963 documented the INR on the MAR as 4.9; and on 05/22/24 during the dayshift, RN #812 documented the INR on the MAR as 4.9. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #11's MAR from 05/15/24 to 05/22/24 revealed the resident was not administered the ordered Coumadin 7.5 mg on 05/15/24 (date of admission). The comment indicated it was a new order. The MAR revealed the resident was administered Coumadin 7.5 mg on 05/16/24, 05/17/24, 05/18/24, 05/19/24, 05/20/24 and 05/21/24. The medication was scheduled to be administered daily from 7:00 P.M. to 11:00 P.M. The record noted the Coumadin was held on 05/22/24 because the resident was in the hospital. Review of Resident #11's medical record revealed no evidence the physician, nurse practitioner or physician assistant were notified of the PT/INR result of 4.9 on 05/20/24 or 05/21/24. Review of Resident #11's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and the resident was on an anticoagulant. Review of Resident #11's progress note dated 05/22/24 at 7:32 P.M., authored by Registered Nurse (RN) #812, revealed the resident notified RN #812 that he blew his nose and blood clots were coming out of his nose and a small amount in his mouth. Vital signs were stable, and the nurse practitioner was notified of the resident's INR level with a new order to hold Coumadin dose until further notice. The resident was made aware. There was no indication an order was obtained to check the resident's PT/INR at that time. Review of an Incident/Offense Report form dated 05/22/24 at 8:48 P.M., authored by Police #506 and Police #507, revealed Resident #11 had called 911 due to bleeding from his mouth and nose. The resident stated he had been bleeding from his nose and gums all day. The resident reported he was on a blood thinner and was taken by stretcher to the hospital. Review of Resident #11's progress note dated 05/22/24 at 9:00 P.M., authored by LPN #963, revealed LPN #963 was exiting another resident's room when EMS staff were observed going into Resident #11's room with a stretcher. The note indicated the resident called them (EMS) himself without letting the nurse know. A face sheet and medication list were sent with the resident to the hospital. Review of Resident #11's social media (Facebook) posts/documentation dated 05/22/24 between 7:00 P.M. and 8:00 P.M. revealed the resident had posted information to the social media site related to his status and health care. This information included when the resident's blood was drawn a few days ago in dialysis, the resident personally delivered the tube of blood to the nurse for the lab to pick up (at the facility). The resident had a hard time clotting at the end of the (dialysis) treatment. Later in the evening, the resident asked LPN #983 if she had the results of the blood work because the resident was reluctant to take the 7.5 mg of Coumadin because he felt his blood was thin. The social media post revealed LPN #983 argued with the resident and said the INR was 1.8. The resident said that it was the bloodwork from 05/16/24 and LPN #983 stated it was the current bloodwork. An unidentified person responded on the resident's social media on 05/22/24 between 7:00 P.M. to 8:00 P.M. to call 911 and to tell them his bleeding would not stop, and his INR was 4.9. (The content of the social media/Facebook post was verified through telephone interview with Resident #11 on 06/13/24 at 3:05 P.M.) (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a police report dated 05/22/24 (incident number 24-01975) revealed upon arrival, the police department observed a large amount of bloody paper towels on Resident #11's bedside table. The resident explained that since his arrival on 05/15/24, he had not received proper care and had documented the improper care on social media to keep track of the lack of care and keep a record to advocate for himself and others in the facility that may not be able to (advocate for themselves). Review of hospital documentation revealed the resident presented to the emergency room (on 05/22/24) with a chief complaint of spontaneous bleeding. The resident had called the squad himself for concerns of spontaneous bleeding. The resident reported he had been having nosebleeds and bleeding from the mouth for the past few days and was concerned about his INR being high. The resident had an admission diagnosis of coagulopathy (bleeding disorder; a condition in which the blood's ability to coagulate (form clots) is impaired. This condition can cause a tendency toward prolonged or excessive bleeding (bleeding diathesis) which may occur spontaneously or following an injury or medical and dental procedures. The resident received Vitamin K intravenously to counteract the effects of the Coumadin and assist in stabilizing his INR levels and was admitted to the hospital from 05/22/24 through 06/03/24 for continued medical care and monitoring. The resident did not return to the facility upon discharge from the hospital. On 05/29/24 at 6:36 A.M. interview with Licensed Practical Nurse (LPN) #963 revealed she was the nurse working and assigned to care for Resident #11 on 05/21/24 during the nightshift from 7:00 P.M. to 7:00 A.M. LPN #963 revealed she did not notice the PT/INR for Resident #11 was out of range until after she had administered Coumadin 7.5 mg on 05/21/24. The LPN verified she did not report the elevated lab to the NP or the fact she had administered the resident's Coumadin without checking the INR first during her nightshift 05/21/24. LPN #963 stated on 05/22/24 at 7:00 P.M., when she came on shift to work, she was notified in the nursing shift to shift report by RN #812 that the NP was made aware of Resident #11's nose and mouth bleeding and the NP then gave an order to hold the Coumadin. LPN #963 stated the resident called for an ambulance to go to the hospital (on 05/22/24) while she was in another room. She stated she was unaware of any concerns until she had observed the squad with a stretcher going into Resident #11's room. LPN #963 stated she printed a face sheet and orders to send with the resident to the hospital and let the NP know the resident requested to be transported to the hospital. LPN #963 stated she was busy on her shift and did not think to call the physician after administering the Coumadin on 05/21/24 when she found out the PT/INR was elevated. Interview on 05/29/24 at 10:02 A.M. with Registered Nurse (RN) #812 revealed she worked dayshift from 7:00 A.M. to 7:00 P.M. on 05/22/24. RN #812 stated she talked to Resident #11 close to shift change around 7:00 P.M. to 7:30 P.M. about his Coumadin dosage and the NP orders to hold the Coumadin on 05/22/24. RN #812 stated the resident did not have concerns when she left the room, and the resident did not request to be sent to the hospital during her shift. She also stated she was not aware of the resident's nosebleed until she went in the room around 6:30 P.M. to answer the resident's call light and had observed the resident's bloody nose and several bloody tissues on his overbed table along with a bloody tissue in his hands RN #812 stated she immediately called the NP at that time and received new orders to hold the Coumadin. The RN denied knowledge of the resident's INR level until he (the resident) reported the bloody nose, and she reviewed the INR value. RN #812 denied an increase in monitoring Resident #11's condition because she stated she was not aware of the resident receiving the Coumadin with a high PT/INR. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 06/04/24 at 6:42 P.M. with Nurse Practitioner (NP) #980 revealed she was not aware of Resident #11's high PT/INR until the resident had the nosebleed and she ordered to hold the resident's Coumadin. The staff notified her the resident had gone out to the hospital (on 05/22/24). She indicated staff did not call her about the resident's abnormally high PT/INR result and they should have notified her (on 05/20/24) so the Coumadin could have been adjusted or held as necessary. Telephone interview on 06/10/24 at 6:03 P.M. with LPN #883 revealed she had administered Resident #11's Coumadin dose on 05/20/24 during the nightshift based on the lab work dated 05/16/24 (and not the lab work from 05/20/24). The LPN indicated the dayshift nurse told her the 05/16/24 lab work was the current lab work available for the resident and stated she did not physically check the lab system to see what the PT/INR was on the lab work obtained on 05/20/24. Telephone interview on 06/10/24 at 6:31 P.M. with Resident #11 with the Administrator and RRN #979 present revealed on 05/22/24, he had reported to RN #812 between 2:00 P.M. and 3:00 P.M. that his nose and gums were bleeding. Resident #11 stated RN #812 assessed his mouth and stated that he must have broken one of his teeth which caused bleeding. She provided a saltwater rinse for the resident. Resident #11 stated between 6:30 P.M. and 6:34 P.M., RN #812 came in and told him that his PT/INR was 4.9 and that his Coumadin was to be held. He stated at that point, he called his friends at the fire department and decided to call EMS for transport to the hospital. He stated he was hospitalized from 05/22/24 to 06/03/24 to get his INR stabilized which included the administration of Vitamin K shots. The resident indicated the hospitalization would not have been necessary if the nursing staff had monitored his lab work closely and reported the abnormal labs to the physician before giving him his Coumadin. Interview on 06/12/24 at 10:30 A.M. with RRN #979 revealed the facility policy was for the dayshift nurses to check the medication cart to ensure Coumadin doses were available for resident administration and the nightshift nurses were responsible to check the PT/INR results and administer Coumadin as ordered. Telephone interview on 06/12/24 at 1:33 P.M. with Laboratory Staff (LS) #502 revealed their company did not call high labs and only called critical labs. When further questioned, she stated it was a different critical level result for each facility and their computer told them when to call the results to the facility. LS #502 revealed their company faxed Resident #11's lab results to the facility on [DATE] at 1:49 P.M., 4:49 P.M. and 5:54 P.M. When asked why the lab faxed the lab results three different times, LS #502 stated multiple lab staff members worked on the labs with high results and that was probably why the results were faxed to the facility three times. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/14/24 at 7:11 A.M. with RRN #975 revealed the nurse who was assigned to care for a resident receiving Coumadin was responsible for calling in the lab work for the PT/INR to the physician/NP. She stated all residents on Coumadin had orders to monitor for signs and symptoms of bruising or bleeding and any adverse effects of anticoagulant therapy. RRN #975 stated the expectations of each physician of those residents on Coumadin were different but in general, all nurses should call immediately for a PT/INR of greater than 3.0 (standard 2.0 to 3.0). RRN #975 confirmed Resident #11's lab work results for his PT/INR were received by the facility (via fax) around 5:30 P.M. on 05/20/24 and LPN #935, who worked dayshift on both 05/20/24 and dayshift on 05/21/24, should have called the physician with the PT/INR results for Resident #11 as well as LPN #883, who worked nightshift on 05/20/24, and LPN #963, who worked nightshift on 05/21/24, should have called the physician/NP regarding Resident #11's elevated PT/INR results. RRN #975 stated Resident #11's NP was notified on 05/22/24 and did not indicate she wanted the resident transported to the hospital. RRN #975 stated the NP wanted the resident's Coumadin held on 05/22/24, but the resident did not feel comfortable with that order and requested his own emergency transport to the emergency room Interview on 06/14/24 at 8:18 A.M. with Fire Department #311 revealed he had responded to Resident #11's 911 call on 05/22/24 and their squad was on scene for 21 minutes. He stated he had observed Resident #11 with bloody towels on the table, bloody tissues, blood in cups and blood down the front of him. Fire Department #311 shared that upon arrival, three staff members were at the end of the hall laughing and talking on their cell phones while the squad team was in the building. No staff were present in the room helping Resident #11. Further interview revealed fire department staff asked the staff members for a mechanical lift to get the resident on a cot for transport and no staff members brought the mechanical lift or even talked to them and/or assessed the resident while the squad was in the room. He stated the resident's room was in deplorable condition with bloody towels/tissues and the floor was sticky (from the resident's blood). Fire Department #311 indicated the entire 21 minutes the squad was in the building, not one staff member had come in to assess, monitor or assist Resident #11 in any way. Fire Department #311 indicated he asked for Resident #11's resident information and the nurse handed him the form without talking to the squad about the resident or resident's care. Review of the undated facility Labs policy revealed the nightshift nurse was responsible for double checking the lab draw list and assuring all residents that were due for scheduled labs were on the requisition. Review of the facility Anticoagulation policy revised 05/27/21 revealed on admission, nursing would identify individuals who were currently anticoagulated. Residents would be monitored for possible complications associated with anticoagulation and providers would be promptly notified of any such complications. Anticoagulation therapy and monitoring would be included in the care plan. The nurse would obtain and verify anticoagulation orders from the provider. In the event there was a change in the dosage of the medication, all changes to the dosage would be made on the MAR. Supplemental orders for anticoagulated residents include antibiotic check, PT/INR frequency check, dose check, check (to verify the) dose in the medication cart was correct and monitor bleeding. Review of the Resident Change in Condition policy revised 11/10/20 revealed the charge nurse would notify the physician/provider/family of significant changes in condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366440	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pointe Health & Rehab Center	402 Golf View Lane Highland Heights, OH 44143

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Food and Drug (FDA) Highlights of Prescribing Information webpage www.fda.com revised 10/2011 revealed to adjust Warfarin (Coumadin) dose to maintain a target INR of 2.5 with an INR range of 2. 0 to 3.0 for all treatment durations (related to treatment of atrial fibrillation). This deficiency represents non-compliance investigated under Master Complaint Number OH00154752 and Complaint Numbers OH00154261, OH00154253 OH00153950 and OH00153809.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366440	A. Building B. Wing	06/14/2024

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than five percent (%). This affected one resident (Resident #33) of four residents reviewed for medication administration. A total of thirty medications were administered with two errors for a medication error rate of 6. 66%. Findings include: Review of Resident #33's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified dementia, essential hypertension and depression. Review of Resident #33's physician orders revealed an order dated 01/23/24 for aspirin chewable 81 mg (milligrams) administer one tablet orally once per day; and an order dated 01/31/24 for vitamin c 500 mg administer two tablets orally once per day. Observation on 05/29/24 at 9:38 A.M. with Registered Nurse (RN) #855 of Resident #33's medication administration revealed ten medications were administered including aspirin 81 mg enteric coated (EC) tablet and vitamin c 500 mg one tablet. Interview on 05/29/24 at 11:36 A.M. with RN #855 confirmed she administered aspirin EC and the order was for aspirin chewable and also administered one vitamin c tablet instead of two as ordered. Review of the Medication Administration policy revised 05/01/10 revealed the facility should ensure authorized personnel, as determined by applicable law, administer medications according to times of administration and determined by the facility's pharmacy committee and/or physician prescriber. This deficiency represents non-compliance investigated under Master Complaint Number OH00154752 and Complaint Numbers OH00154253, OH00153950 and OH00153809.