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	01/20/2026

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of communication documentation, and facility policy review, the facility failed to ensure private information had not been shared with individuals that had not been authorized. This affected one resident (#78) of two reviewed for privacy. The facility census was 76.Findings include: Review of Resident #78's closed medical records revealed an admission date of 07/11/25 and a discharge date of 08/04/25. Diagnoses included post surgical care, difficulty walking and need for personal care assistance.Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had intact cognition.Review of Resident #78's demographics sheet revealed Resident #78 was listed as his own person and his emergency contact listed was a sister. No other contacts had been listed on Resident #78's demographics sheet.Review of a progress note dated 07/11/25 timed 6:57 P.M. authored by Registered Nurse (RN) #302 revealed Resident #78's daughter had called to discuss Resident #78's pain medications and RN #302 had provided information related to Resident #78's pain level and the use of as needed pain medication. The progress note further stated Resident #78's daughter had expressed concerns related to frequent rounding and daughter had been updated and informed she was more than free to call and update the facility daily.Review of a progress note dated 07/15/25 timed 4:28 P.M. authored by Social Services (SS) #223 revealed a care conference meeting was held in Resident #78's room with the daughter present and medications, orders, therapy goals, and discharge plans were discussed. Review of progress note dated 07/21/25 timed 4:54 P.M. authored by the Administrator revealed Resident #78's daughter had called and left a message for a return call from the Director of Nursing (DON). Due to the daughter not being a power of attorney (POA), Resident #78 was asked if it was ok to call her back and Resident #78 stated he would update his daughter and stated he would prefer that the facility not call her at that time. Review of communication documentation in the form of text messages dated 07/17/25 and 08/01/25 revealed communication between SS #223 and a family member of Resident #78. The text messages discussed Resident #78's care including the therapy appeal process, an upcoming appointment, his discharge plan, and home health care. Interview on 01/14/26 at 9:55 A.M. with SS #223 revealed a care conference was held in July 2025 with Resident #78 and his daughter. SS #223 stated at the time of the care conference Resident #78 had allowed his daughter to receive information, however after the care conference Resident #78 had asked that his daughter not receive any more information. SS #223 stated Resident #78 had given him permission to share the information with his family member. SS #223 confirmed there had been no documentation regarding Resident #78's permission to share information. Review of facility policy titled HIPPA 1 Privacy Policy-Overview and Definitions revised 01/08/26 revealed facility will treat Protected Health Information (PHI) in accordance with the policy and may not disclose PHI except as specifically permitted. This deficiency represents noncompliance investigated under Complaint Number 2648607.

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure routine bathing care was provided to residents. This affected two residents (#23 and #31) of three residents reviewed for activities of daily living. The facility census was 76. Findings include:1. Review of Resident #23's medical records revealed an admission date of 03/19/25. Diagnoses included muscle weakness and need for personal care assistance. Review of the care plan dated 03/19/25 revealed Resident #23 had self care deficits. Interventions included assist with activities of daily living (ADL) care that included grooming, and dressingReview of the MDS assessment dated [DATE] revealed Resident #23 had intact cognition. Resident #23 was dependent for bathing, personal hygiene and toileting. Review of physician orders for January 2026 revealed Resident #23 was ordered a shower on Tuesdays and Fridays on day shift.Review of Resident #23's plan of care documentation for November 2025, December 2025, and January 2026 to date revealed the resident had only one documented shower on 01/13/26.Interview on 01/12/26 at 11:56 A.M. with Resident #23 revealed she had not received a shower in several months and had only had two showers since she was admitted . Resident #23 stated the staff had wiped her down in bed, however when she had asked for a shower the staff had often given her an excuse as to why they couldn't give her a shower. At time of interview, Certified Nursing Assistant (CNA) #233 had entered and stated she was unaware Resident #23's showers were scheduled for Tuesdays and Thursdays and stated she had been aware Resident #23 had complained about not receiving her showers. 2. Review of Resident #31's medical records revealed an admission date of 08/25/24. Diagnoses included muscle weakness and need for personal care assistance. Review of the MDS assessment dated [DATE] revealed Resident #31 had intact cognition. Resident #31 required moderate assistance with bathing, personal hygiene and bed mobility and was dependent with transfers. Review of the care plan updated 11/30/25 revealed Resident #31 required assistance with ADL care. Interventions included allow extra time to complete ADL's.Review of physician orders for January 2026 revealed Resident #31 was ordered showers on Tuesdays and Fridays. Review of Resident #31's plan of care documentation for December 2025 and January 2026 to date revealed the resident had only one documented shower on 01/11/26.Interview on 01/07/26 at 2:54 P.M. with Resident #31 revealed she had not been assisted out of bed or received a shower in about a month. Resident #31 stated since she had changed rooms the staff had told her she wasn't on a list and they had not gotten her out of bed. Observation of Resident #31 at time of interview revealed hair appeared to be matted and greasy and resident had a slight odor.Interview on 01/14/26 at 1:04 P.M. with Regional Registered Nurse (RRN) #301 reviewing Resident #23 and #31's shower documentation revealed Resident #23 had no documented shower for November 2025 or December 2025 and one shower documented on 01/13/26. RRN #301 confirmed Resident #31's shower documentation revealed the resident had no showers documented in December 2025 and only one shower documented on 01/11/26.Review of facility policy titled Activities of Daily Living revised 08/12/20 revealed appropriate staff will perform ADL care for residents including but not limited to personal hygiene and transferring.This deficiency represents noncompliance investigated under Complaint Number 2669629.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of relevant personnel records, and facility policy review, the facility failed to ensure timely incontinence care was provided to residents. This affected two residents (#23 and #24) of three residents observed and reviewed for incontinence care. The facility census was 76. Findings include: 1.Review of Resident #23's medical records revealed an admission date of 03/19/25. Diagnoses included muscle weakness and need for personal care assistance. Review of care plan dated 03/28/25 revealed Resident #23 was incontinent of bowel and bladder. Interventions included Resident #23 was to receive assistance with toileting.Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #23 had intact cognition. Resident #23 was dependent on staff for toileting and was incontinent of bowel and bladder.Interview on 01/07/26 at 12:11 P.M. with Resident #23 revealed she had been soiled for several hours on occasions and staff had not assisted her with incontinence care which had lead to sores on her bottom. Resident #23 stated the previous evening she had used her call light for incontinence care and the light had remained on from 1:00 A.M. to 3:45 A.M. with no staff coming in to assist her. Interview on 01/07/26 at 12:58 P.M. with Certified Nursing Assistant (CNA) #233 revealed she had assisted Resident #23 with incontinence care at approximately 8:00 A.M. and had observed Resident #23 saturated in urine and she had required an entire bed change. CNA #233 stated she had observed residents who had been soiled many times when she arrived to start her shifts at 7:00 A.M. and stated management had been aware. Interview on 01/14/26 at 8:55 A.M. with Resident #23 revealed she had not been changed since approximately 5:00 P.M. the previous evening (01/13/26) until approximately 7:00 A.M. Resident #23 stated she had placed her call light on around 12:00 A.M. but no staff had come and she had fallen back asleep. Resident #23 stated when she had woken up again her call light was off, however she was still incontinent. Resident #23 stated she had started to bang on the wall for assistance and stated an aide had come in and said she could not provide her with incontinence care because there were not enough linens. Resident #23 stated she had informed the nurse about the situation and stated she had been left incontinent until approximately 7:00 A.M. when the day shift aide had assisted her. Resident #23 further stated she had been made aware of multiple other residents who had not received incontinence care that morning. 2.Review of Resident #24's medical records revealed an admission date of 10/03/23. Diagnoses included stroke with left sided weakness, and muscle weakness.Review of MDS assessment dated [DATE] revealed Resident #24 had intact cognition. Resident #24 was dependent with toileting and was incontinent of bowel and bladder.Review of care plan updated 11/10/25 revealed Resident #24 was incontinent of bowel and bladder. Interventions included provide incontinence care after each incontinence episode. Interview on 01/07/26 at 10:55 A.M. with Resident #24 revealed she was the [NAME] President of resident council and had residents who had complained about not receiving timely toileting assistance. Resident #24 stated residents' complaints included having been soiled for long periods of time without staff assisting them with toileting or incontinence care. Interview on 01/14/26 at 9:06 A.M. with Licensed Practical Nurse (LPN) #266 revealed she had been made aware of residents who had not been changed during the evening and night shift (01/13/26 into 01/14/26), however she had not been made aware until approximately an hour prior.Interview on 01/14/26 at 9:17 A.M. with Resident #24 revealed she had not been changed throughout the evening.Interview on 01/14/26 at 9:24 A.M. with CNA #216 revealed she had arrived at approximately 7:00 A.M. and had been made aware by Resident #23 she had not been changed throughout the evening. CNA #216 stated she had provided Resident #23 with incontinence care and had to change her entire bedding. CNA #216 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated she had also been made aware Resident #24 had also been left incontinent during the evening and also had to provide her with an entire bed change as both residents were heavily soiled.Interview on 01/14/26 at 10:25 A.M. with Regional Registered Nurse (RRN) #301 revealed she had been made aware of residents who had not been changed during the evening shift and stated the Administrator had called the CNA who had been assigned both residents the evening and night prior. At 10:51 A.M., the Administrator entered and stated CNA #203 was the CNA who had been responsible for Residents #23 and #24, and CNA #203 had been terminated via phone for the lack of care provided to residents the night prior. The Administrator further stated CNA #203 was the aid assigned to Resident #23 on 01/06/26 when she had previously stated she had not been assisted with incontinence care. Review of CNA #203's separation form dated 01/14/26 revealed CNA #203 was terminated because she failed to check and change residents on her assignment the evening of 01/13/26.Review of facility policy titled Activities of Daily Living revised 08/12/20 revealed appropriate staff will perform ADL care for residents including but not limited to personal hygiene and toileting.This deficiency represents non-compliance investigated under Complaint Numbers 2669629 and 2648607.

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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** Based on record review, interview, review of self reported incident (SRI) and corresponding investigation, and facility policy review, the facility failed to ensure pain was comprehensively assessed and pain medications was administered timely after resident complaint of severe pain. This affected one resident (#18) of three residents reviewed for pain management. The facility census was 76. Findings include:Review of Resident #18 ' s medical records revealed an admission date of 04/25/24. Diagnoses included muscle weakness, need for personal care assistance and left femur fracture (diagnoses updated 11/16/25).Review of physician orders for November 2025 revealed Resident #18 was ordered Tylenol (an over the counter mild pain reliever) 650 milligrams (mg) every six hours as needed for pain and Methocarbamol (anti-spasmodic) 500 mg twice a day as needed.Review of care plan dated 10/10/24 and updated 11/28/25 revealed Resident #18 was at risk for pain related to osteoarthritis. Interventions included administer medications as ordered and evaluate and record effectiveness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had intact cognition. Resident #18 was dependent with toileting, bathing and personal hygiene and required maximum assistance with bed mobility. Review of a progress note dated 11/15/25 timed 7:28 P.M. authored by Licensed Practical Nurse (LPN) #297 revealed an aide had alerted her that Resident #18 ' s left leg did not look normal at 6:30 P.M. and Resident #18 was screaming in pain when being repositioned to be changed. LPN #297 had assessed Resident #18 ' s leg and noted it to be rotated in and left hip had yellow-tinged skin. LPN #297 had asked Resident #18 where the pain was and Resident #18 stated it was coming from her left groin area. Physician had been notified and an x-ray had been ordered. Continued review of Resident #18's record revealed no evidence a comprehensive pain assessment, including a pain rating and description of the quality of the pain, had been completed on 11/15/25. Review of a progress note dated 11/16/25 timed 7:17 A.M. authored by LPN #204 revealed x-ray results had suggested Resident #18 had a left hip fracture.Review of a progress note dated 11/16/25 timed 7:50 P.M. authored by LPN #297 revealed Resident #18 was ordered to be sent to the hospital for treatment. Review of the Medication Administration Record (MAR) for November 2025 revealed Tylenol only been administered on 11/05/25 and only one dose of Methocarbamol had been administered on 11/15/25 at 9:00 P.M. for pain. Review of a self reported incident form dated 11/16/25 revealed Resident #18 had complained of left hip pain and pain medications had been offered and given as ordered.Interview on 01/08/26 at 7:44 A.M. with Resident #18 revealed she had been sent to the hospital a few months ago for a broken leg as a result of having been placed back in bed too hard after a transfer. Resident #18 stated the pain in her leg had gotten worse a few weeks later and that is when she went to the hospital. Resident #18 stated she had pain but could not recall when she had received pain medication. Interview on 01/12/26 at 1:31 P.M. with Certified Nursing Assistant (CNA) #233 revealed CNA (#284) had asked her to come into Resident #18's room on 11/15/25 to observe Resident #18's leg. CNA #233 stated she had observed Resident #18's leg to have been turned outward, her hip was protruding out and Resident #18 was yelling out in pain. CNA #233 stated CNA #284 had immediately informed the nurse and the nurse had assessed the resident. Interview on 01/12/26 at 2:37 P.M. with CNA #284 revealed on 11/15/25 she had entered Resident #18's room to assist her with incontinence care and repositioning and she had observed Resident #18's left leg was turned outward and was yelling in pain when she had attempted to move her. CNA #284 stated she had asked CNA #233 to look and also assist with moving Resident #18 and she had also informed the nurse immediately. CNA #284 stated the nurse had come in and assessed Resident #18.Telephone interview on 01/12/26 at 3:06 P.M. with LPN #297 revealed at approximately 6:30 P.M. on 11/15/25 an aide had alerted her (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #18's leg did not look right. LPN #297 stated she had immediately went and assessed Resident #18 and had observed Resident #18's leg was rotated inward and had a large yellow bruise on her left hip. LPN #297 stated Resident #18 had been yelling out in pain when being moved. LPN #297 stated she could not recall if she had medicated Resident #18 at that time. Review of SRI on 01/12/25 at 3:24 P.M. with Regional Registered Nurse (RRN) #301 confirmed investigation had included pain medication had been administered, however Resident #18's MAR had indicated Methocarbamol had not been administered until 9:00 P.M. and Resident #18 had been yelling out in pain at approximately 6:30 P.M. Resident #18 was not recorded to have received any doses of Tylenol, for which she had an as-needed order, between when the pain was identified and when the resident was transferred to the hospital for evaluation. Review of facility policy titled Pain Management Protocol revised 10/24/22 revealed when determined the residents pain will need pharmacological intervention, documentation of medications will be located in the electronic medication record. This deficiency represents non-compliance investigated under Complaint Numbers 2669629 and 2648607.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were not left unattended in residents' rooms. This affected one resident (#19) of four residents observed for unattended medications. The facility census was 76.Findings include: Review of Resident #19's medical record revealed an admission date of 05/25/25. Diagnoses included dementia, mild cognitive impairments and hallucinations.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had impaired cognition. During an observation made on 01/14/26 at 12:38 P.M. upon entering Resident #19's room, a cup of medications were observed on a dresser underneath Resident #19's television that contained three white pills. Further observation revealed a second medication cup on Resident #19's night stand located next to her bed that contained a total of eight medications. Interview with Resident #19 at the time of observation revealed she was unaware of when the medications had been delivered and stated staff would sometimes bring in her medications while she was sleeping and she would be unaware they are there. Interview on 01/14/26 at 12:42 P.M. with Licensed Practical Nurse (LPN) #234 revealed she had administered Resident #19's morning medications between 8:00 A.M. and 9:00 A.M. LPN #234 stated she had observed Resident #19 consume her medications. Observation at time of interview revealed LPN #234 confirmed the medication cup with three white pills located in Resident #19's room as well as the medication cup with the eight medications. LPN #234 stated she was unaware of what the three white pills were as she had not administered those and confirmed the medication cup with the eight pills were Resident #19's morning medications. LPN #234 stated she thought the resident took her morning medications this morning and proceeded to remove both medication cups and exited Resident #19's room. LPN #234 confirmed medications should not be left unattended in resident rooms. Review of facility policy titled General Dose Preparation and Medication Administration revised 01/01/13 revealed facility should not leave medications or chemicals unattended and observe the residents consumption of medications. This deficiency represents an incidental finding identified during the course of the complaint investigation.