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	05/06/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy the facility failed to ensure facility staff notified Resident #90's responsible party of a change of condition. This affected one resident (Residents #90) out of three reviewed for notification. The facility census was 89.Findings include:Review of Resident #90's medical record revealed an admission date of [DATE] and diagnoses included acute and chronic respiratory failure, congestive heart failure, type two diabetes mellitus without complications, and end stage renal disease.Review of Resident #90's care plan dated [DATE] included Resident #90 had self-care and mobility deficits related to decline in functional abilities related to impaired gas exchange, shortness of breath upon exertion, debilitation and overall functional decline. Resident #90's needs would be met with staff assistance as needed. Interventions included Resident #90 required setup help for eating as tolerated; Resident #90 used a mechanical lift and required the assistance of two staff.Review of Resident #90's Quarterly Minimum Data Set assessment dated [DATE] included Resident #90 had moderate cognitive impairment. Resident #90 required setup or clean-up assistance for eating and required substantial to maximal assistance for toileting hygiene, bathing and lower body dressing. Resident #90 was always incontinent of urine and bowel. Resident #90 did not have a swallowing disorder. Review of Resident #90's progress notes dated [DATE] at 7:39 P.M. included Certified Nursing Assistant (CNA) #381 alerted Licensed Practical Nurse (LPN) #344 that Resident #90 was unresponsive. Resident #90 was sitting upright, unresponsive, with emesis noted on his gown. Resident #90 did not have a pulse or respirations, a code blue was initiated immediately, Resident #90 was repositioned and CPR was initiated per facility protocol. Emergency response was activated and EMS was notified. Oxygen was applied at 10 liters per minute (high flow) and the AED was applied with no shock advised. CPR was continued until EMS arrived and Resident #90 was transported to the ED for evaluation and management. Certified Nurse Practitioner (CNP) #392, Physician and facility management were notified. Resident #90's family was notified by insurance CNP #392. Subsequently, notification was received that Resident #90 expired at the hospital.Interview on [DATE] at 11:06 A.M. with CNP #392 revealed she was not present in the facility when Resident #90 coded, but she worked for an insurance company, and it was the facility policy that the insurance company was always the first call when a resident had an issue. CNP #392 revealed Registered Nurse (RN) #326 called her and asked her if she was comfortable calling the family and she agreed to notify the family. CNP #392 indicated RN #326 told her Resident #90 was found unresponsive, a code was initiated, CPR was started and EMS was called. CNP #392 revealed she told RN #326 to call her with updates, and she called 20 minutes later and said EMS arrived, Resident #90 was shocked three times and transferred to the local hospital ED. CNP #392 revealed RN #326 contacted her at 6:04 P.M. and she spoke to her at 6:20 P.M. CNP #392 indicated she called Power of Attorney (POA) #393 who was also Resident #90's niece at 6:38 P.M., she did not answer, then she texted her at 6:40 P.M. and said she needed to speak with POA #393 urgently. POA #393 called CNP #392 at 7:05 P.M. and was notified of Resident #90's change of condition.Interview on [DATE] at 11:24 A.M. with RN #326 revealed on [DATE] she called CNP #392 to notify her of (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #90's code and she did not contact Resident #90's family or POA #393 because CNP #392 said she would contact the family. RN #392 revealed she did not remember if she asked CNP #392 to call the family or CNP #392 told her she would call the family. RN #326 indicated the insurance company was very specific about patient care.Interview on [DATE] at 11:57 A.M. of Regional Director of Clinical Services (RDCS) #391 revealed CNP #392 contacted POA #393 and notified her of Resident #90's change of condition and told her everything. RDCS #391 revealed CNP #392 knew everything the nurses knew and it was totally acceptable that she notified the family.Interview on [DATE] at 12:48 P.M. of RDCS #391 revealed CNP #392 often communicated directly with families regarding resident care and if there was a change of condition CNP #392 was notified right away. RDCS #391 revealed she was aware POA #393 was not happy the facility staff did not call her. Review of the facility policy titled Resident Change in Condition Policy revised [DATE] revealed the licensed nurse would recognize and intervene in the event of a change in resident condition. The Physician/Provider and Family/Responsible Party would be notified as soon as the nurse identified the change in condition and the resident was stable. In the event of an emergency situation, 911 would be called immediately and the Physician or Provider/Family/Responsible Party would be notified as soon as practicably possible. This deficiency represents non-compliance investigated under Complaint Number 2988794.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on closed record review, review of an Emergency Medical Service (EMS) report, review of the facility policy, review of National Institute of Health information, review of the Ohio Board of Nursing Standards of Practice and interview the facility failed to ensure Resident #91, who had advance directives for a Full Code status (life saving measures to be provided if necessary) was comprehensively assessed and provided timely monitoring after experiencing an acute change of condition to ensure prompt and necessary medical intervention was provided to the resident. Immediate Jeopardy with Actual Harm and subsequent death began on [DATE] at 10:05 A.M. when Resident #91 was noted to be pale, disoriented and confused; with changes to his eyes/vision and lung congestion. Resident #91 was assessed to be tachycardic with a pulse of 102 beats per minute. The facility lacked documented evidence to support Resident #91 was comprehensively re-assessed or monitored for additional changes/decline in condition until [DATE] at 3:30 P.M. at which time the resident was found unresponsive, cold to the touch, and without a pulse. EMS arrived on [DATE] at 3:47 P.M. and assessed Resident #91 to be cold to the touch, had obvious signs of rigor mortis and was pronounced deceased at the scene. This affected one resident (#91) of three residents reviewed for change in condition.On [DATE] at 4:01 P.M., Regional Director of Clinical Services (RDCS) #391, the Administrator, and Assistant Director of Nursing (ADON) #306 were notified Immediate Jeopardy began on [DATE] when the facility failed to comprehensively and adequately assess and monitor Resident #91, who was a Full Code, after he showed serious changes in condition on [DATE] at 10:05 A.M. Despite signs like pallor, confusion, vision changes, lung congestion, and a high pulse, there was no documented follow up assessment until 3:30 P.M., when the resident was found unresponsive with no pulse. EMS arrived shortly after and confirmed the resident had already developed rigor mortis and was deceased . The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions:- On [DATE] from 4:00 P.M. until 10:00 P.M. the Director of Nursing (DON) and designee assessed all in-house residents for a change in condition by completing a full set of vital signs to identify any abnormal vital signs. Any negative findings were addressed immediately. All findings would be brought to the facility Quality Assurance and Performance Improvement (QAPI) committee.- On [DATE] from 4:00 P.M. until 10:00 P.M. the DON and designee completed an audit of in-house residents by reviewing progress notes, orders and assessments for the last 48 hours, to ensure that all changes of condition were appropriately monitored by staff. Any negative findings were addressed immediately. All findings would be brought to QAPI. - On [DATE], the DON and designee reviewed residents who expired or were transferred to the hospital for the past 30 days to determine if those residents received necessary care and monitoring. All findings were brought to QAPI. - On [DATE] from 4:00 P.M. until 10:00 P.M. RDCS #391 reviewed the facility Change in Condition Policy. - On [DATE] from 4:00 P.M. until 10:00 P.M. the DON and Human Resources Manager (HRM) #330 completed education for all facility licensed nurses on Change in Condition Policy for recognizing, evaluating, and monitoring resident changes in condition.- On [DATE] RDCS #391 and HRM #330 completed education with all licensed nursing staff regarding appropriate documentation of monitoring of change of condition. Education consisted of monitoring a change in condition per policy and as needed to include vital signs. - On [DATE] the DON and designee completed education with Certified Nursing Assistant staff regarding timely reporting of any change of condition to the charge nurse. - On [DATE] from 5:30 P.M. through 6:00 P.M. a QAPI meeting was held regarding the facility Abatement Plan addressing the documentation of the continued monitoring of residents' change of condition. In attendance were the DON, the Administrator, RDCS #391, Assistant Director of Nursing #306, HRM #330, and Medical Director #395 (participated via telephone). - Beginning [DATE] the facility implemented a plan for the DON/designee to audit five residents, five days a week for three weeks, who were experiencing a change in condition to ensure they were monitored, evaluated and (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	treated timely, by reviewing progress notes, vital signs, orders and assessments. All negative findings would be brought to QAPI. - On [DATE] the DON and designee completed a comprehensive head to toe assessment on all in-house residents. - On [DATE] the Administrator and designee conducted interviews with 59 alert and oriented in-house residents to identify if they had concerns with not properly being monitored or treated after a change of condition. - Beginning on [DATE] the DON and designee would complete three comprehensive head-to-toe assessments a week for three weeks to ensure compliance. All findings would be brought to QAPI - Beginning on [DATE] the Administrator and designee will conduct five interviews a week for three weeks with alert and oriented residents to identify if they had any concerns with the timely reporting of change in condition. All findings would be brought to QAPI - Beginning on [DATE]/26 the DON and designee would audit all hospital discharges and expired residents' charts for three weeks for proper monitoring and treatment of a change of condition. - Beginning on [DATE] the DON and designee would audit hospital discharges and expired residents' charts randomly for proper monitoring and treatment of a change of condition.Although the Immediate Jeopardy was removed on [DATE] the deficiency remained at a Severity Level 2 (no actual harm with the potential for minimal harm that is not Immediate Jeopardy) as the facility was continuing implement corrective action and ensure ongoing compliance. Findings include: Review of Resident #91's closed medical record revealed an admission date of [DATE] with diagnoses including dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, schizophrenia, bilateral conductive hearing loss, and legal blindness. Resident #91 expired at the facility on [DATE]. Review of Resident #91's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #91 had moderate cognitive impairment. The assessment revealed Resident #91 required set-up (staff) assistance for eating and required substantial to maximal assistance for toileting hygiene, bathing, the ability to move from lying on his back to sitting on the side of the bed, and chair/bed-to chair transfers. Resident #91 was dependent for lower body dressing and was always incontinent of urine and bowel. Resident #91 did not reject care during the seven-day assessment look-back period.Review of Resident #91's care plan edited [DATE] revealed Resident #91 had the potential for alteration in vision impairment related to legal blindness. Resident #91 was able to utilize a whiteboard to make needs known due to hearing loss. Resident #91 would maintain current vision ability as evidenced by no injuries and feeling safe and secure in the environment through next review. Interventions included Resident #91 would utilize a communication board; use large print materials with Resident #91.Review of Resident #91's nursing progress notes dated [DATE] at 5:43 P.M. through [DATE] at 10:05 A.M. did not reveal evidence progress notes were written regarding Resident #91's health status during this time period.Review of Resident #91's Weekly Observation dated [DATE] revealed Resident #91 had no new skin issues and did not have shortness of breath or trouble breathing when sitting at rest. Resident #91 was occasionally incontinent of bowel and bladder. Physical and verbal behavior symptoms were not exhibited in the last seven days.Review of Resident #91's vital sign record including temperature, pulse, respirations, blood pressure, oxygen saturation, blood sugar, meal intakes and snacks, urine output, emesis and bowel movement revealed from [DATE] at 10:49 P.M. through [DATE] at 10:05 A.M. no vital sign monitoring was completed or documentation of oxygen saturation, meal intakes, urine output or bowel movements documented. On [DATE] at 8:08 A.M., 9:55 P.M. and [DATE] at 8:43 A.M. Resident #91's pain was documented it was zero on a scale of 0 to 10, 0 being no pain and 10 being the worst pain. Review of Resident #91's nursing progress note dated [DATE] at 10:05 A.M. revealed Resident #91 appeared very drowsy and his skin color was pale. Resident #91's vital signs included a blood pressure of 112/87, pulse 102 (tachycardic), temperature 97.7 Fahrenheit and oxygen saturation of 98 percent. There was no assessment of the resident's respiratory rate documented. The note revealed Licensed Practical Nurse (LPN) #371 asked Registered Nurse (RN) #359 to assess Resident #91. RN #359 stated Resident #91's lung sounds were not clear, and he needed a chest x-ray, and laboratory testing including a Complete Blood Count (CBC) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with differential and a Basic Metabolic Panel (BMP). The note included Nurse Practitioner (NP) #386 was contacted and stated the directive RN #359 gave was exactly what should be done. The assessment of the resident did not include a comprehensive assessment of the resident's mental status or neurological status. In addition, the note did not address and/or provide intervention related to the resident's new onset drowsiness.Review of Resident #91's progress notes dated [DATE] at 10:05 A.M. through [DATE] at 4:19 P.M. revealed on additional written evidence Resident #91 was monitored or re-assessed after the resident's change in condition was identified. A chest x-ray (reported on [DATE] at 12:08 P.M.) revealed Resident #91 had new mild left lower lung airspace disease, possible atelectasis, though concerning for pneumonia in the clinical setting of infection.Review of a Prehospital Care Report Summary dated [DATE] revealed a call was received at 3:41 P.M. EMS was dispatched to the facility for Resident #91, who was unresponsive and not breathing with Cardiopulmonary Resuscitation (CPR) in progress. EMS was on the scene and had contact with Resident #91 at 3:47 P.M. The summary included Resident #91 was dead at the scene, and resuscitation was attempted without transport. The summary also included Resident #91 had obvious signs of rigor (According to National Institutes of Health (NIH) sources, rigor mortis generally begins to set in approximately two hours after death) and was cold to the touch. Resident #91 did not have a pulse and no pulse was evident. Resident #91 was placed on the monitor, and it showed asystole. With the obvious signs of death and asystole on the monitor the hospital was contacted, and EMS spoke with medical control for a time of death. Physician #390 gave a time of death at 3:53 P.M. EMS turned the scene over to the facility and returned to their quarters. Review of a police investigative report dated [DATE] at 3:42 P.M. revealed police were dispatched to the facility regarding an unresponsive resident (Resident #91). Upon arrival staff members were performing CPR on Resident #91. Resident #91 had no detectable pulse, his extremities were cold to touch, while his chest area remained warm. EMS initiated life-saving measures which were unsuccessful and they subsequently contacted medical control to obtain an official time of death. Resident #91 was pronounced deceased at 3:53 P.M. by hospital Physician #390. LPN #371 stated Resident #91 had been acting unusual throughout the day, describing him as off and noting a decreased appetite. Review of Resident #91's progress note dated [DATE] at 4:19 P.M. (after the resident had passed away) revealed a chest x-ray was completed at approximately 11:30 A.M. Resident #91 was cleaned up after the x-ray and placed in a semi-Fowlers position. The note included Resident #91 was monitored by staff. Resident #91's x-ray results were sent to NP #386 and new orders were received. Upon entering Resident #91's orders, Certified Nursing Assistant (CNA) #345 notified LPN #371 that Resident #91 had a change of condition. LPN #371 entered Resident #91's room and found him without a pulse. LPN #371 immediately started chest compressions, yelled out code blue, a code blue was initiated and EMS was contacted. Resident #91 was pronounced deceased after multiple rounds of CPR. Resident #91's family, provider and the Director of Nursing were contacted. The progress note did not include means of how the resident was being monitored during this time period, including any written evidence of the resident's vital signs or a comprehensive physical assessment being obtained/completed after 10:05 A.M. Interview on [DATE] at 7:55 A.M. with Registered Nurse (RN) #359 revealed on [DATE] LPN #371 was Resident #91's nurse and around 10:00 A.M. LPN #371 told her Resident #91 did not look well and she wanted a second opinion. RN #359 accompanied LPN #371 to Resident #91's room and assessed him. RN #359 revealed Resident #91 was hard of hearing, she called his name a few times, then tapped him. After RN #359 tapped him Resident #91 opened his eyes and she could hear junkiness in his lungs. RN #359 revealed LPN #371 took Resident #91's vital signs. RN #359 revealed she told LPN #371 to contact Nurse Practitioner (NP) #386 and have her order a chest x-ray and bloodwork. RN #359 revealed she was assigned to a different nursing unit and did not see Resident #91 again that day until she was called to his room when he coded and cardiopulmonary resuscitation was initiated. RN #359 revealed she was responsible for ventilating Resident #91 with the Ambu bag (during the code). RN #359 revealed LPN #371, LPN #385, and RN #326 were in (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #91's room assisting with the code, and EMS arrived and care was transferred to them. RN #359 revealed Resident #91 was not taken to the ED but passed away at the facility.Interview on [DATE] at 8:06 A.M. with Certified Nursing Assistant (CNA) #345 revealed in the morning on [DATE] when she went in Resident #91's room to check on him she noticed he looked pale and his eyes were wandering to the outside. CNA #345 indicated she told LPN #371 something was wrong with Resident #91. CNA #345 revealed Resident #91 had a STAT chest x-ray and he had a cloud in his chest. CNA #345 stated Resident #91 was a check and change and she checked on him every two hours. Although not documented in the medical record, CNA #345 stated on [DATE] she checked Resident #91 at 9:00 A.M., 11:00 A.M., 1:00 P.M. and at around 3:25 P.M. when she checked him he was gone. CNA #345 revealed she had LPN #371 come to Resident #91's room and LPN #371 asked her to time when the compressions were started which was at 3:31 P.M. CNA #345 stated LPN #371 had been in and out of Resident #91's room. CNA #345 revealed every time she checked on Resident #91 during the day he did not look like he was feeling well and she was nervous that when she went into his room he would be gone. CNA #345 revealed Resident #91's normal skin tone was pink and that day he was white, he was coughing a lot and he mumbled. Resident #91 loved coffee and CNA #345 knew something was wrong because he did not drink his coffee. CNA #345 revealed she took care of Resident #91 before [DATE], knew him and on [DATE] he was different and his eyes did not focus on her. Resident #91 did not throw up or have a bowel movement.Review of a late entry progress note dated [DATE] at 9:06 A.M., authored by NP #386, for [DATE] at 10:00 A.M. revealed Resident #91 was seen for chronic condition management at the facility (telehealth visit) and Resident #91's lungs had wheezing and rhonchi, and he was disoriented and confused. A STAT chest x-ray was ordered, and labs were to be drawn in the morning ([DATE]). Diagnostic tests reviewed for today's visit included the most recent labs and imaging results, and Resident #91's outside chart from the facility was reviewed. Discussed with nursing and patient (Resident #91). Interview on [DATE] at 12:02 P.M. with LPN #385 revealed she assisted with Resident #91's chest compressions during CPR. LPN #385 revealed she was close to Resident #91's room when the code was called, he was in bed, the head of the bed was lowered, and a board was placed underneath him. Resident #91 was pale, he was not responding and his skin was cold to the touch. LPN #385 revealed she did not know if Resident #91 was stiff, but stated he was definitely cold. LPN #385 revealed Resident #91 was a quiet man, was hard of hearing and staff had to write on a board to communicate with him. LPN #385 revealed sometimes Resident #91 went to activities or would wander around in the hall, but he was in bed the day he passed and did not get up.Interview on [DATE] at 9:29 A.M. with Paramedics #387, #388 and #389 revealed they responded to Resident #91's 911 call on [DATE] at 3:41 P.M. and when they arrived at the facility the staff were performing CPR, Resident #91 was unresponsive, he was not breathing and they took over CPR. Resident #91 did not have a pulse, he was cold to the touch, had mottled skin on his limbs and rigor was setting in. Paramedic #387 indicated a phone call was made to med control to get a time of death and CPR was stopped when they got the time of death. Paramedics #387, #388 and #389 indicated they were told the last time Resident #91 was seen by staff was an hour before, it seemed like longer than an hour, but they could not say. Paramedic #387 revealed Resident #91 had obvious signs of death and met their criteria for dead on arrival (DOA). Interview on [DATE] at 9:33 A.M. with LPN #371 revealed on [DATE] at 10:00 A.M. she went in to medicate Resident #91 and he was not himself. Resident #91 always drank his coffee, and his coffee was still in the cup. Resident #91 did not look good, but stated she felt his blood pressure and vitals were good, although his heart rate was a little high. LPN #371 revealed she asked RN #359 to come with her to Resident #91's room and assess him. After LPN #371 and RN #359 entered the room LPN #371 indicated she asked Resident #91 if he was okay, and while they were standing there he coughed and they could hear the mucous in his chest. LPN #371 revealed RN #359 told her she thought Resident #91 needed a STAT CXR, a BMP and a CBC, and she contacted NP #386, reported Resident #91's vital signs and NP #386 ordered the chest x-ray, and BMP and CBC. LPN #371 revealed she told CNA #345 that Resident #91 needed to be monitored (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and LPN #371 stated she kept going back and forth to his room. LPN #371 revealed staff checked on him periodically between their other duties and walked by his room and looked in. LPN #371 revealed she was very busy with passing medications to the residents, providing treatments, talking to physicians' (etc), but stated she checked on Resident #91 when she could. LPN #371 revealed she wasn't sure, she thought she took another set of vital signs but might not have written the vital signs in Resident #91's progress note. LPN #371 stated she was in the room when Resident #91's chest x-ray was completed at 11:13 A.M. LPN #371 revealed she did not have access to the system to check Resident #91's x-ray results and she asked RN #359 to check the results. While RN #359 was obtaining Resident #91's x-ray results around 3:30 P.M. CNA #345 called her into Resident #91's room and when she ran in the room she found him without a pulse. A code was initiated and CPR was started. EMS arrived and called it because Resident #91 had died. Resident #91's chest was warm, his hand was cold, and Resident #91 liked his room to be cold. LPN #371 stated during the interview she had last seen Resident #91 10 to 15 minutes before he coded. However, there was no indication provided during the interview or in the resident's medical record as to the condition of the resident at this time.Interview on [DATE] at 10:13 A.M. with NP #386 revealed Resident #91 was a paranoid schizophrenic, she knew him well and he had a history of non-compliance with his medical history and medications mainly due to paranoia. NP #386 revealed on [DATE] the nurse on duty called and reported that Resident #91 did not seem right. Resident #91's lungs were junky, his vital signs were stable and she ordered bloodwork. NP #386 revealed she did not think he needed sent to the hospital and if something changed she would expect Resident #91's vital signs to be checked and to be called with an update. NP #386 revealed the nurse knew how he was and would have kept an eye on him. NP #386 revealed the visit was a telephone visit, she did not see Resident #91 on [DATE] and the physical exam in her note came from discussion with the nurse. NP #386 revealed rigor would occur hours after death, and it would not happen if a resident expired in the past hour or so. NP #386 revealed she was not told the last time the staff saw Resident #91 prior to him being found unresponsive. Interview on [DATE] at 10:53 A.M. with Regional Director of Clinical Services (RDCS) #391 and the Administrator revealed on [DATE] at 10:00 A.M. Resident #91 was not feeling well but they stated they believed he was stable. RDCS #391 revealed [DATE] was a Sunday and there wasn't a manager present in the facility.Interview on [DATE] at 3:07 P.M. with the Administrator and RDCS #391 revealed Resident #91 was a long-term resident, and the facility was not required to document on him. RDCS #391 verified a weekly skin check was completed on [DATE] and the facility only needed to chart when he had a change of condition. RDCS #391 revealed Resident #91 had a change of condition, he had congestion and was drowsy. LPN #371 had RN #359 assess Resident #91. RDCS #391 revealed RN #359 sent Resident #91's x-ray report to NP #386 at 3:21 P.M. and received an order for an antibiotic. RDCS #391 revealed the nurses know to check for an x-ray result in about four hours, and that was the average time to get a report. Interview on [DATE] at 8:48 A.M. with RN #359 revealed on [DATE] she was not Resident #91's nurse and she went in his room with LPN #371 because LPN #371 asked her to. RN #359 revealed she did not do vital signs or neuro checks when she was in Resident #91's room; LPN #371 obtained vital signs but she stated she did not see her complete neuro checks. During this interview, the RN indicated she was not the assigned nurse for Resident #91 on this date; therefore, she did not follow up to re-assess Resident #91 following the identification in his change in condition at 10:05 A.M. or to ensure the resident was being comprehensively monitored by other staff prior to him being found unresponsive at 3:30 P.M.Review of the facility policy titled Resident Change in Condition Policy revised [DATE] included the licensed nurse would recognize and intervene in the event of a change in resident condition. A significant change of condition was a decline in the resident's status that impacts more than one area of the resident's health status and/or one that required interdisciplinary review and/or revision to the care plan. The nurse would address any emergency care required given the situation and then gather information prior to contacting the physician/provider. The physician/provider would discuss with the (continued on next page)

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	366440	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nursing staff and the resident and/or family the benefits and risks of diagnosing and managing the situation in the facility or elsewhere as needed. If, after discussion with the physician/provider, the care or observation could not reasonably be provided in the facility, the physician would authorize transfer to the hospital or alternative facility. In the event of an emergency, 911 would be called immediately.Review of the Ohio Board of Nursing standards for a change of condition (OAC 4723-4-07) included the Ohio Board of Nursing standards required nurses to immediately assess, document and report any significant change in a patient's condition. Key standards for a change of condition included to collect and document comprehensive data regarding the change. Analyze the data and promptly report the change to the healthcare team. Modify the nursing care plan and implement new interventions and reassess the patient to determine the effectiveness of the interventions. All assessments, communications, and interventions must be documented in the medical record. The nurse must maintain competence and provide care that is current with professional standards. Review of a National Institute of Health article titled Methods of Estimation of Time Since Death dated [DATE] included rigor mortis was the post-mortem stiffening of muscles caused by the depletion of adenosine triphosphate (ATP) from the muscles, which was necessary for the breakdown of actin-myosin filaments in the muscle fibers. Rigor mortis appeared approximately two hours after death in the muscles of the face, progressed to the limbs over the next few hours, completing between six to eight hours after death.This deficiency represents non-compliance investigated under Complaint Number 2988794.

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F 0690 Level of Harm - 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 observation, record review, hospital record review and interview, the facility failed to ensure adequate monitoring and treatment of urinary complications related to an indwelling catheter. Actual harm occurred on 04/27/26 to Resident #35 after an indwelling catheter was removed due to reported pain and burning, the resident's urine output was not thoroughly monitored, and when the catheter was reˆinserted the resident continued to have significant pain with no output, resulting in hospitalization where an acute kidney injury and approximately 1000 milliliters (mL) of urinary retention was identified. This affected one resident (#35) of two residents reviewed for urinary catheters. The facility census was 89.Findings include:Review of Resident #35's medical record revealed an admission date of 03/28/26 with diagnoses including obstructive uropathy, stroke and diabetes.Review of care plan dated 03/31/26 revealed Resident #35 had an indwelling Foley catheter related to diagnoses of obstructive uropathy. Interventions included assess for signs and symptoms of discomfort with urination or related to the catheter, assess/record/report signs and symptoms of urinary tract infection that included pain, burning, blood-tinged urine, and no output, check for wetness and change per routine as needed, record output amount every shift and as needed.Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 had intact cognition. The assessment revealed Resident #35 was dependent with toileting, had a urinary catheter and was incontinent of bowel.Review of Resident #35's current physician orders for April 2026 included pain assessment every shift, change Foley catheter as needed and record output every shift.Review of the recorded vital sign records from 04/24/25 to 04/26/26 revealed Resident #35 had zero pain on a scale of 0-10. On 04/24/26 at 6:21 A.M. Resident #35 had medium urine output (no actual amount of urine recorded, despite having a urinary catheter for accurate measurement of urine), on 04/24/26 at 6:18 P.M. Resident #35 had 200 milliliters (mL) of urine, on 04/25/26 at 2:05 A.M. 100 mL of urine, and on 04/25/26 at 2:10 P.M. medium urine output.Review of a progress note dated 04/24/26 timed 5:38 P.M. authored by Licensed Practical Nurse (LPN) #385 revealed Resident #35 had returned from an appointment had had complaints of burning pain when urinating. Recommendations for a urinalysis and culture were noted and orders were received from Nurse Practitioner (NP) #386 for the urinalysis and (urine) culture.Review of Medication Administration Record (MAR) revealed Resident #35 received Tylenol 325 milligrams (mg) three tablets on 04/24/26 at 8:40 A.M. No other Tylenol administration was recorded.Review of a progress note dated 04/25/26 timed 5:07 P.M. authored by LPN #348 revealed Resident #35 was having burning and discomfort from his catheter site and NP #386 was notified. NP #386 gave orders to remove the catheter and leave it out for a few days and monitor urine output. However, record review revealed no urine output was recorded in the medical record after the catheter was removed.Review of MAR revealed Resident #35received Tylenol on 04/25/26 at 2:05 A.M. and 12:20 P.M.Review of post fall huddle form, not included in the medical record, dated 04/26/26 timed 8:00 P.M. revealed Resident #35 had a fall due to attempting to self-transfer to use the bathroom. Resident #35 was without signs of injury and the form noted the resident's brief was noted to have been wet. Review of a progress note dated 04/27/26 timed 9:43 A.M. authored by Registered Nurse (RN) #359 revealed NP #386 was called and gave to reinsert Resident #35's catheter and continue to monitor urine output.Observation on 04/27/26 at 11:40 A.M. revealed an ambulance had arrived outside the facility. Emergency Services (EMS) had proceeded to Resident #35's room. At time of observation RN #359 had informed Regional Director of Clinical Services (RDCS) #391 that Resident #35 was being sent to the hospital due to low urine output over the weekend. Review of a progress note dated 04/27/26 timed 12:02 P.M. authored by RN #359 revealed Resident #35's catheter was reinserted with no urine output noted. The note included the resident had been bleeding from insertion site. NP #386 was called and orders were received to send Resident #35 to the hospital for (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	further observation. Review of a progress note dated 04/27/26 timed 4:17 P.M. authored by RN #359 revealed Resident #35 was admitted to the hospital for an acute kidney injury and was being treated with antibiotics. Review of hospital paperwork dated 04/27/26 revealed Resident #35 had a past medical history of a chronic indwelling Foley catheter and had presented to the emergency department for inability to place a urinary catheter due to the facility had met resistance while trying to place the catheter and Resident #35 had bleeding. Upon arrival to the emergency department a bladder scan had been used and Resident #35 was noted to have more than 1000 milliliters (mL) of urine in his bladder. Lab work was completed and Resident #35 was assessed to have an acute kidney injury. Resident #35 was admitted to the hospital and as of 04/30/26 the resident had not returned to the facility.Interview on 04/28/26 at 7:45 A.M. with LPN #385 revealed she had cared for Resident #35 on 04/24/26 and he had an appointment. LPN #385 stated upon return from his appointment in the afternoon (couldn't recall time) Resident #35 had complains of pain and burning while urinating; however, the LPN stated it was mild. LPN #385 stated she did not recall administering any pain medication to Resident #35 at that time. LPN #385 further stated she had been made aware Resident #35 had low urine output over the weekend and stated RN #359 had contacted NP #386 and orders were received to reinsert Resident #35's catheter. LPN #385 stated upon reinserting Resident #35's catheter he had bleeding (the resident was on a blood thinner). LPN #385 stated RN #359 then had contacted NP #386 and orders were received to send Resident #35 to the hospital for evaluation. A telephone interview on 04/30/26 at 11:50 A.M. with NP #386 revealed she had received a text message from the facility (unable to state who sent the message) on 04/25/25 at approximately 5:00 P.M. that stated Resident #35 was having pain and discharge around his catheter site. NP #386 stated the text message had included asking if Resident #35's catheter could be left out for a few days and NP #386 stated she had agreed. NP #386 stated she had not been made aware of any concerns related to Resident #35's catheter until 04/27/26 when she had been advised Resident #35 was having a lot of bleeding and she had advised he be sent to the hospital. NP #386 stated she had not been aware of any concerns related to low urine output. During the interview NP #386 provided the text message for review. Review of text message dated 04/24/26 timed 3:12 P.M. (author unknown) included Resident #35 was having some discomfort and burning and had brown liquid and blood when the catheter was removed and asked if catheter could remain out for a few day to which NP #386 had replied ok. A telephone interview on 04/30/26 at 3:28 P.M. with LPN #348 revealed she had cared for Resident #35 on 04/25/26 from 7:00 A.M. to approximately 11:00 P.M. LPN #348 stated at approximately 5:00 P.M. Resident #35's brother had approached her and stated Resident #35 was having pain and discomfort from his catheter and had asked if it could be changed. LPN #348 stated she had checked Resident #35's orders and there were standing orders to change his catheter as needed. LPN #348 stated she proceeded to remove Resident #35's catheter, Resident #35 was having pain and there was brown discharge. LPN #348 stated as she proceeded to replace Resident #35's catheter Resident #35 had screamed in pain, there was no urine output and Resident #35 had asked her to stop. LPN #348 stated she had contacted NP #386 and had informed her of Resident #35 screaming in pain and the discharge and NP #386 had stated it was ok to leave the catheter out for a few days and to monitor his output. LPN #348 stated she had recalled administering Resident #35 Tylenol; however, could not recall if she had signed the medication off in the medical records. LPN #348 stated she had not been made aware of any complaints of pain previously. LPN #348 further stated upon removing Resident #35's catheter there was approximately 500 mL of urine in his catheter bag and stated she had relayed the amount to the aide for her to document. LPN #348 stated Resident #35 had no further complaints. LPN #348 stated she had returned to the facility on [DATE] and denied knowledge of the resident having complaints of pain during her shift. LPN #348 stated Resident #35 had a fall on the evening of 04/26/26 and she had assisted getting Resident #35 off the floor and she had observed his brief had been wet. LPN #348 stated she had since been asked to provide a statement due to her lack of progress note(s) to reflect Resident #35 having urine output (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	between 04/25/26 and 04/26/26. This deficiency represents non-compliance investigated under Complaint Number 2988794.