STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366459	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Pointe Transitional Care	4355 Laurel Road Brunswick, OH 44212

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to prepare and distribute food and ice under sanitary conditions. This had the potential to affect all residents who received meal trays and drinks from the kitchen. The facility census was 78.Finding Include:Observation on 04/27/26 from 8:20 A.M. to 8:45 A.M. revealed two small ice scoops and one large ice scoop laying on top of the ice machine. To the right of the ice machine was a container on the wall that was used for placing the large ice scoop when not in use. Additional observation of the kitchen revealed the can opener had a buildup of a black substance with dirt particles on and around the blade area. Observation on 04/29/26 from 11:55 A.M. to 12:45 P.M. revealed Employee #358 placing her thumb in a plate of food while preparing the plate for service. Furthermore, when the plates were being prepared for distribution to the residents Employee #340 placed their thumb in a plate of food. Interview on 04/27/26 at 8:44 A.M. with Employee #233 during the kitchen tour confirmed that three ice scoops were laying on the top of the ice machine and a dirty black substance on and around the blade area of the can opener. Interview on 04/29/26 at 11:15 A.M. with Corporate Chef #341 confirmed Employee #358 and #341 placed their thumb in a plate of food. Corporate Chef #341 immediately approached both employees and asked them to put on a glove to plate the dishes. Review of the dietary cleaning schedule for the month of April 2026 revealed no sections for routine cleaning of the can opener.This deficiency represents non-compliance investigated under Complaint Number 2733312.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and record review, the facility failed to ensure infection control practices were followed for isolation precautions and proper glove use. This affected two residents (Resident #16 and Resident #69) and had the potential to affect all 78 residents who resided in the facility.Findings include:1.Review of the medical record revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, clostridium difficile, chronic obstructive pulmonary disease, malnutrition, anxiety, depression. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 04/08/26 revealed the resident had impaired cognition. The resident was dependent with transfers. Review of the physician orders dated 04/08/26 revealed an order for contact isolation due to diagnosis of Clostridioides difficile (C-diff). Review of Resident of the care plan dated 04/08/26 revealed the resident was in contact isolation requiring staff and visitors to donn a gown and gloves prior to entering Observation on 04/27/26 at 9:38 A.M. or Resident #16's room revealed a sign on the door that read contact precautions everyone must: Clean their hands before room entry and discard gloves before room exit. Put on a gown before room entry and discard gloves before exit. Reusable equipment must be cleaned and disinfected. Licensed Practical Nurse (LPN) #288 was in Resident #16 room administering medications. LPN #288 was not wearing a gown and was wearing gloves. LPN #288 walked to the door and took off her gloves, exited the room and then sanitized her hands with hand sanitizer. Interview on 04/27/26 at 9:40 A.M. with LPN #288 stated she only needed to wear gloves and not gown to administer medications. LPN #288 stated gowns are only needed if providing direct care with Resident #16. LPN #288 stated she used hand sanitizer to clean her hands. Observation on 04/27/26 at 9:42 A.M. of Resident #16's room revealed Certified Nursing Assistant (CNA) #248 and #246 were preparing to enter the room with the mechanically transfer device. CNA #248 and #246 put on a gown and gloves and entered the room. The resident was transferred from the bed to the chair. CNA #248 removed her gown and gloves and left the room with mechanical left device. CNA #248 did not wash her hands or wipe down the mechanical left machine. CNA #246 removed her gown and gloves and sanitized her hand after exiting the room with hand sanitizer. Observation on 04/27/26 at 9:55 A.M. revealed CNA #248 and #246 coming out of a room on the 500 hall with the mechanical lift device. Interview on 04/27/26 at 9:55 A.M. with CNA #248 verified she did not wash her hands prior to exiting the room, however she sanitized her hands at the nurse's cart located down the hall. CNA #248 stated she did not wipe the machine down after uses in contact isolation room. There were no wipes available and CNA #248 had not been trained to wipe down the mechanical device. Interview on 04/27/26 with CNA # 246 verified she did not wash her hands however she sanitized them as she left the room. CNA #246 stated she was not trained to wipe down the mechanical lift after use in a isolation room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility policy titled Standard and Transmission-based Precautions revealed contact precautions are measures that are intended to prevent transmission infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment. Review of the facility policy titled Hand Hygiene dated 11/28/17 stated after removing personal protective equipment staff will perform hand hygiene. Hand washing with soap and water is required when there is a Clostridium difficile or Norovirus outbreak or high rates of infection in the facility. Review of the Center of Disease Control and Prevention guidance titled Preventing C-diff' stated in a healthcare setting all healthcare professionals will clean their hands before and after care. While caring for patients with C-diff infection, healthcare professionals will use certain precautions like wearing a gown and gloves. This will prevent the spread of C-diff to themselves and other patients. 2. Resident #69 was admitted to the facility on [DATE] with re-entry on 06/30/25 with diagnoses that included dementia, heart failure, heart disease, chronic kidney disease, need for assistance with personal care, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #69 was cognitively intact, did not reject care, required maximal assistance for toileting hygiene, and she was frequently incontinent of bowel and bladder. Review of the care plan dated 02/22/26 revealed Resident #69 required assistance with activities of daily living with a goal to have her needs met, interventions included provide assistance based on needs, peri-care with each incontinent episode, and assistance needed with toileting care. An observation on 04/03/26 at 2:43 P.M. with CNA #251 and #324 of incontinence care for Resident #69 revealed after incontinence care was completed and without changing her contaminated gloves CNA #251 proceeded to immediately touch the bed control to adjust the bed for Resident #69, with the same gloves CNA #251 picked up the basin containing the water from the procedure and dumped it into the toilet, with the same gloves CNA #251 touched the paper towel dispenser and then wiped out the basin, and then CNA #251 removed her gloves and washed her hands. An interview on 04/03/26 at 3:01 P.M. with CNA #251 verified the above findings. Review of the facility policy titled Hand Hygiene, dated 11/28/17 revealed hand hygiene assisted in preventing the spread of infection, staff were to perform hand hygiene when indicated, staff were to perform hand hygiene before and after resident contact, after contact with bodily fluids or contaminated surfaces, and hand hygiene was to be completed after contact with objects and surfaces in the resident's environment.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 and record review the facility failed to ensure Resident #3's representative was notified the resident was transferred to the hospital. This affected one resident (Resident #3) of one resident reviewed for notification.Findings include: Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including acute and chronic respiratory failure, amyotrophic lateral sclerosis (ALS), edema, chronic obstructive pulmonary disease,, tracheostomy status, and pneumonia.Review of the compressive Minimum Data Set (MDS) assessment, dated 02/127/26 revealed the resident had was really understood and memory problems. The resident was dependent on activities of daily living.Review of the profile page revealed Resident #3 was her self-representative. Emergency Contact #1 had a phone number and email address. Emergency Contact #2 had a phone number.Review of the progress notes dated 04/23/26 revealed Resident #3 was sent via 911 to the emergency room (ER). The note indicated the nurse attempted to call daughter and would continue to try to contact. The note did not indicate if a message could be or was left with the daughter.Interview on 04/27/26 at 3:39 P.M. with Resident #3's Emergency Contact #1 revealed she was upset due to Resident #3 being sent to the hospital and there was no notification provided. Emergency Contact #1 revealed she received a phone call from the hospital stating the resident was in the emergency room.Interview on 04/28/26 at 12:20 A.M. with Registered Nurse #225 revealed she sent Resident #3 to the ER. RN #225 stated she called the Emergency Contact #1 twice and was unsuccessful with notification and she did not leave a message after each call. RN #225 stated she did not think about leaving one. RN #225 stated Emergency Contact #2 did not have a number listed on the profile page.Interview on 04/28/26 at 3:08 P.M. with Social Service Designee (SSD) #249 revealed there was no power of attorney (POA) listed on file. The Emergency Contact #1 would be the person to notify.Review of the facility policy titled Change of Condition dated 10/18/2001 revealed the Charge Nurse will notify the resident, physician and guardian/interested family member of an emergence of unstable condition or disease.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with facility failed to ensure Resident #3 and Resident #21's care plan was revised and implemented. This affected two residents (Resident #3 and Resident #21) of 24 residents reviewed for care plans. Findings include:1.Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, heart failure, depression, irritable bowel syndrome, neuromuscular dysfunction of bladder, acute kidney disease, and anxiety.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognition was intact. The resident was dependent on activities of daily living. The resident did not receive antibiotic however had an intravenous (IV) access.Review of the April 2026 Medication Administration Record (MAR) revealed order for to flush peripherally inserted central catheter (PICC) line with 10 milliliter (ml) of normal saline, after medication administration and to flush PICC line worth 10 ml of normal saline before medication administration every shift.Review of the Care Plan for Resident #21 revealed there was no care plan for IV therapy and maintenance. Interview on 04/30/26 at 8:55 A.M. with the Director of Nursing (DON) verified there was no IV or maintenance care plan for Resident #21. 2. Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including acute and chronic respiratory failure, amyotrophic lateral sclerosis (ALS), edema, chronic obstructive pulmonary disease, tracheostomy status, and pneumonia.Review of the compressive Minimum Data Set (MDS) assessment, dated 02/27/26 revealed the resident had was really understood and memory problems. The resident was dependent on activities of daily living and was incontinent of bowel and bladder.Review of the physician orders for April 2026 revealed orders dated 04/24/26: Catheter Care ever shift. Change indwelling catheter for signs of infection as needed, monitor foley catheter stabilization device daily.Observation on 04/27/26 at 10:54 A.M. revealed Resident #3 was laying in bed on a ventilator, tube feed running, and foley draining.Review of the Care Plan dated 02/20/26 revealed Resident #3 has an alteration in elimination due to being incontinent of bowel and indwelling catheter place due to wound and diuretic use. The care plan was not updated to reflect the catheter until 04/28/26.Interview on 04/30/26 at 8:55 A.M. with the DON revealed Resident #3's care plan for indwelling catheter was updated during chart audits on 04/28/26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview the facility failed to ensure residents were comprehensively assessed to determine the level of (staff) assistance required for mechanical lift transfers and failed to ensure resident care plans were in place to ensure an appropriate level of assistance was provided to prevent an accident/injury. This affected three residents (#20, #61, and #79) of three residents reviewed for accidents. The facility identified 34 additional residents (#2,#3, #4, #5, #6, #9, #10, #12, #13, #16, #21, #24, #28, #34, #37, #38, #42, #43, #48, #49, #50, #51, #59, #62, #63, #66, #69, #73, #76, #80, #82, #84, #95 and #96) who required a mechanical lift for transfers. The census was 78.Findings include: 1.Review of the medical record for Resident #20 revealed an admission date of 01/14/26 with diagnoses including nondisplaced comminuted fracture of left patella, osteoarthritis, chronic obstructive pulmonary disease and restless legs syndrome. Resident #20 was cognitively intact.Review of the April 2026 orders for Resident #20 revealed an order for mechanical lift for all transfers. The order did not specify if one or two people were required to assist with the mechanical lift transfer. Review of the April 2026 treatment administration record (TAR) revealed Resident #20 had an order for mechanical lift for all transfers. The administration record did not specify if one or two people were required to assist with the mechanical lift transfer. Review of the care plan, initiated on 01/14/26, for Resident #20 revealed she required a mechanical lift, but it did not specify if one or two people were required to assist with the mechanical lift transfer. Review of the Kardex, information provided to certified nursing assistants on a resident's activity of daily living (ADLs) needs, initiated on 01/15/26, revealed Resident #20 used a mechanical lift for mobility needs. It did not specify if one or two people were required to assist with the mechanical lift. Review of the transfer task for Resident #20 revealed the resident was totally dependent (on staff) for transfers except for a couple marked entries as extensive assistance or activity did not occur. The task documentation noted the resident needed two-person assistance, primarily as occurring three or more times per shift and using a mechanical lift.Interview on 04/27/26 at 10:34 A.M. with Resident #20 revealed the facility sometimes used one person to help with mechanical lift transfers, stating it's sometimes hard to find someone.2. Review of the medical record for Resident #61 revealed an admission date of 07/28/24 with diagnoses including fusion of spine, hemangioma of intra-abdominal structures, congestive heart failure, need for assistance with personal care and Parkinson's Disease.Review of the quarterly Minimum Data Set (MDS) 3.0 Resident #61 was cognitively intact. Review of the April 2026 TAR for Resident #61 revealed he required a mechanical lift until 04/27/26 at night. It did not specify if one or two people were required to assist with the mechanical lift. Review of the Kardex initiated on 08/21/24 revealed Resident #61 used a mechanical lift for mobility needs. It did not specify if one or two people were required to assist with the mechanical lift. Review of the transfer task for Resident #61 revealed he was totally dependent for transfers and was marked as needing two-person assistance, primarily occurring twice a day using a mechanical lift.Interview on 04/27/26 at 10:42 A.M. with Resident #61 revealed the facility only had one person to help with mechanical lift at times. He stated he did not want to identify the staff who were doing (by themselves) it as he did not want to get them in trouble. The resident shared he believed there was only one staff to do the transfer because the facility did not have enough staff. 3. Review of the medical record for Resident #79 revealed an admission date of 01/29/26 with diagnoses including fibromyalgia, atrial fibrillation, diabetes with neuropathy and generalized anxiety disorder.Review of the quarterly MDS 3.0 dated 02/24/26 revealed Resident #79 was cognitively intact and dependent on staff for transfers.Review of the April 2026 TAR for Resident #79 revealed she required a mechanical lift for transfers every shift. It did not specify if one or two people were required to assist with the mechanical lift. Review of the Kardex initiated on 12/31/25 for Resident #79 revealed she used a mechanical lift for all transfers. It did not specify if one or two people were required to assist with the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	mechanical lift. Review of the transfer task for Resident #79 revealed transfers did not occur most of the time but when they did, the resident was totally dependent (on staff). The task data noted there were two staff members when they used the mechanical lift.Interview on 04/27/26 at 10:46 A.M. with Resident #79 revealed the facility just had one person assisting her when using the mechanical lift. Review of the manufacturer's guide for the mechanical lift, dated 2022, read although (mechanical lift company) recommends that two assistants be used for all lifting, preparation, transferring from and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case.Observation on 04/27/26 at 9:42 A.M. of Resident #16's room revealed Certified Nursing Assistant (CNA) #248 and CNA #246 entered the room with the mechanical lift device. CNA #248 and #246 together placed the pad under Resident #16 and hooked the sling to the mechanical lift. CNA #248 operated the lift while CNA #246 guided Resident #16 from the bed to the chair to ensure proper alignment while lowering into the chair. CNA #248 and #246 unhooked the sling from the mechanical device and left the room. Interviews on 04/27/26 from 10:31 A.M. through 11:30 A.M. with Licensed Practical Nurse (LPN) #264 and CNA #275, revealed they were told they must have two staff members to use a mechanical lift. CNA #275 revealed we normally had two people but a lot of times there was only one while using the mechanical lift.Interview on 04/29/26 at 3:13 P.M. with Regional Nurse (RN) #343 revealed it was staff preference to use two staff for mechanical lifts, but they could use one person for the mechanical lift per manufacturer guidelines. However, review of the sampled resident's medical records revealed no evidence of an assessment or evaluation of the health care professional for each individual case (as per the manufacturer's guide).Interview on 05/04/26 at 9:46 A.M. with CNA #284 revealed the Kardex for resident care just identified if a resident used a mechanical lift, not how many people should assist.Interview on 05/04/26 at 9:52 A.M. with RN #334 revealed while using a mechanical lift she uses two people she was not sure how staff would determine if a resident required one staff or two staff to assist with a mechanical lift transfer. Interview on 05/04/26 at 10:00 A.M. with LPN #272 revealed resident care plans did not specify how many people were required to assist each resident during a mechanical lift transfer; the care plan just noted which machine to use.Interview on 05/04/26 at 10:05 A.M. with ADON #330 revealed the facility did not complete resident assessments for transfer safety related to the use of the mechanical lift and the number of staff assistance required. The ADON indicated therapy helped determine assistance levels for walking and transfers but not for mechanical lift transfers.Interview on 05/04/26 at 10:32 A.M. with ADON #310 revealed the facility policy was to use two people to assist with lift transfers. The ADON stated the facility would not indicate one person for lift assistance so no assessment would be done to determine how many staff was better for a resident.Interview on 05/04/26 at 11:12 A.M. with DON revealed staff should use two people for mechanical lift transfers. There would be no distinction between one or two people for assistance as best practice was for two people to assist a resident during a mechanical lift transfer. The DON revealed if she knew a staff member was completing a mechanical lift transfer without a second person assisting, she would give a disciplinary action.Interview on 05/04/26 at 1:50 P.M. with Administrator revealed the facility did not have a facility policy for mechanical lifts. They followed the manufacturer's guidelines.Review of the DME checklist titled Power Lift Competency Checklist, dated 2017, revealed a list of yes no questions including identifying weight capacity and sling size as well as demonstrating maneuvering the lift; however, it did not distinguish if the staff demonstrated both one and two person transfers as part of the competency and/or how this determination would be made if applicable.This deficiency represents non-compliance investigated under Complaint Number 2697149.

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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 observation, interview, and record review the facility failed to ensure proper infection control measures were implemented for care and treatment of Resident #6's urinary catheter and failed to ensure Resident #5 urinary tract infection was addressed timely. This affected two residents (Resident #5 and #6) of three reviewed for urinary catheters. The census was 78.Findings include:1.Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including constipation, stress incontinence, type 2 diabetes, heart failure, dementia, anxiety, chronic respiratory failure, and schizophrenia. Review of the progress note dated 04/10/26 at 10:20 A.M. revealed an order received to perform straight catheterization for urine collection due to incontinence. The procedure was performed using sterile technique and the urine specimen was sent to the lab. Review of the lab results final report revealed the specimen was collected at 4/10/26 at 12:00 A.M. and was received in the lab on 04/11/26 at 12:00 A.M. with the final results approved on 04/15/26 at 11:30 A.M. The urine analysis preliminary report resulted on 04/13/26 with mixed flora present. The final report identified the Kiebsiella pneumoniae as the organism. There was no evidence the resident's physician was notified of the final results on 04/15/26. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 04/13/26 revealed the resident was cognition was intact. The resident was dependent on activities of daily living. Review of the progress note dated 04/16/26 at 10:54 A.M. revealed the Nurse Practitioner (NP) was notified of the urinary analysis results and gave an order for Levoflaxin 750 milligram (mg), an antibiotic, for three days. Review view of the pharmacy log for the automatic medication delivery system revealed on 04/16/26 there was was only one Levoflaxin for 250 mg available to pull. Review of the Medication Administration Record (MAR) for April 2026 revealed Levoflaxin 750 mg was sign off as administered on 04/17/26 at rise. Interview on 04/30/26 at 10:08 A.M. with Licensed Practical Nurse (LPN) #296 stated she took the order from the NP for Levoflaxin and sent it into the pharmacy, but did not order the antibiotic to be STAT. Interview on 04/30/26 at 2:00 P.M. with the Director of Nursing (DON) verified the results were received on 04/15/26 at 11:30 A.M. and the physician was notified until 4/16/26 at 10:54 A.M. The DON stated the results were sent by fax. The facility receives so many faxes and it takes a while to get through all the faxes. The DON stated the facility has automatic medication delivery system at the facility. The system held one Levoflaxin in 250 mg and did not have enough pills to complete the 750 mg dose, confirming the first dose of antibiotic was given on 04/17/26. 2. Resident #6 was admitted to the facility on [DATE] with a re-entry date of 05/26/24 with diagnoses that included heart disease, kidney disease, chronic obstructive pulmonary disease (lung disease), prostate cancer, obstructive and reflux uropathy (blocked urine flow along the urinary tract), (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and urine retention. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #6 was moderately cognitively impaired, did not reject care, was dependent for toileting hygiene, required moderate assistance for personal hygiene, and had an indwelling urinary catheter (a catheter that is left in place to continually drain the bladder). Review of the care plan dated 04/10/26 revealed the following: Resident #6 required extensive assistance with activities of daily living with a goal have his needs met, interventions included to provide catheter care as ordered; Resident #6 had alteration in elimination related to urinary retention and urinary catheter with a goal to be free from complications due to the urinary catheter, interventions included catheter as ordered and as needed, drainage bag in place as needed, and monitor for signs and symptoms of a urinary tract infection. Review of the physician orders revealed the following an order for a 16 French (catheter size) Coude (a special type of catheter used to get across blockages) catheter with a 30 milliliter (ml) balloon to continuous drainage dated 11/24/25. Review of the nursing progress notes from 04/05/26 to 04/28/26 revealed absence of documentation related to Resident #6 manipulating his urinary catheter drainage bag and if the drainage bag was secured to the bed. An observation on 04/27/26 at 11:53 A.M. revealed Resident #6 was raising his bed vertically and the catheter drainage bag was noted to be dangling in the air not secured to the bed, Resident #6 then lowered his bed back down. An interview on 04/27/26 at 11:57 A.M. with Registered Nurse (RN) #221 verified the catheter drainage bag was not secured to the bed. An observation on 04/28/26 at 3:11 P.M. revealed Resident #6's catheter drainage bag was lying on the floor. An interview at 3:11 P.M. with Licensed Practical Nurse (LPN) #288 verified the catheter drainage bag was lying on the floor. This deficiency represents non-compliance investigated under Complaint Number 2697149 and Complaint Number 1400716.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366459	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Pointe Transitional Care	4355 Laurel Road Brunswick, OH 44212

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review the facility failed to ensure oxygen was administered per physician order for Resident #93. This affected one Resident (#93) of three reviewed for respiratory care. The census was 78. Findings include:Resident #93 was admitted to the facility on [DATE] and was discharged on 03/14/26 with diagnoses that included heart failure, chronic respiratory failure, chronic obstructive pulmonary disease (COPD, a type of lung disease), atrial fibrillation (an abnormal heart rhythm), and diabetes.Review of the care plan revealed the following: Resident #93 had respiratory deficiencies with a goal to have a reduced risk of respiratory complications dated 12/25/25 with interventions that included administer oxygen as ordered, and monitor for signs and symptoms of impaired respiratory function; Resident #93 required oxygen with a goal for oxygen levels to be kept at desired levels as set by the physician dated 12/24/25, with interventions that included oxygen as ordered, medications as ordered, and observed for signs and symptoms of difficulty breathing. Review of the physician orders revealed Resident #93 was ordered oxygen one to five liters per minute (lpm) by nasal cannula to maintain oxygen saturation of 90 percent (%) every shift for COPD, dated 12/26/25.Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #93 was moderately cognitive impaired, did not reject care, required supervision to moderate assistance with activities of daily living, used supplemental oxygen, and utilized hospice care. Review of Resident #93's medical record from 02/28/26 to 03/14/26 revealed the record was absent of documentation that the resident's physician or hospice providers changed the oxygenation order for Resident #93.Review of the Medication Administration Record (MAR) from 03/01/26 to 03/14/26 revealed the following: on 03/03/26 night shift oxygen was documented at six lpm; on 03/04/26 day shift and night shift oxygen was documented at six lpm; on 03/07/26 day shift oxygen was documented at six lpm; on 03/08/26 day shift oxygen was documented at six lpm; on 03/10/26 night shift oxygen was documented at six lpm, on 03/11/26 day shift and night shift oxygen was documented at six lpm; and on 03/12/26 day and night shift oxygen was documented at six lpm. An interview on 05/04/26 at 9:43 A.M. with Regional Nurse #343 verified the above findings. An interview on 05/04/26 at 10:59 A.M. Licensed Practical Nurse (LPN) #325 revealed oxygen settings were to be checked to ensure it was at the correct setting; if a resident was unable to maintain blood oxygen saturation levels of greater than 90% with current physician orders a provider was to be notified; nursing staff were not to increase oxygen outside of order parameters. A review of the facility policy titled Oxygen Administration, dated 07/30/24 revealed oxygen was administered with professional standards of practice, oxygen was administered by physician order, and the physician was to be notified as needed for changes with the use of oxygen. This deficiency represents non-compliance investigated under Complaint Number 2791156.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366459	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Pointe Transitional Care	4355 Laurel Road Brunswick, OH 44212

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to maintain a medication error rate of less than five percent (%). The medication error rate was calculated to be 7.14% and included two medication errors of 28 medication administration opportunities. This affected one resident (Resident #5) of four residents observed for medication administration.Findings include: Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including constipation, stress incontinence, type 2 diabetes, heart failure, Dementia, anxiety. Chronic respiratory failure, and schizophrenia.Review of the comprehensive Minimum Data Set (MDS) assessment, dated 04/13/26 revealed the resident was cognition was intact. The resident was dependent on activities of daily living and received insulin.Review of the physician orders for April 2026 revealed an order including but not limited to Humalog Kwik Pen to inject per sliding scale 201-250 give 4 units; subcutaneously before meals and at bedtime, and orders for Lantus Solostar pen injector inject 80 units once a day. Observation on 04/29/2026 at 7:22 A.M. of medication administration with Registered Nurse (RN) #329 for Resident #5 revealed RN #329 obtained Resident #5's blood sugar level of 228 and prepared the insulin. RN #329 took off the cap to the Lantus insulin pen, attached the needle and dialed 80 units. RN #329 prepared the Humalog quick pen; pulled off the cap, attached needle and dialed 4 units of insulin. RN #329 walked into the room and stated I'm going to prime the pen and turned the Lantus pen vertically and pushed the injector button releasing insulin and dialed the pen back to 80 units and injected the insulin into Resident's left lower abdomen. RN #329 primed the Humalog insulin pen by holding the pen vertically and releasing some insulin. RN #329 redialed the pen to 4 units and injected the insulin into the resident's left lower abdomen.Interview 04/29/26 at 7:30 A.M. with RN #329 verified she dialed the dose and then primed the pens. RN #329 state she did not know to hold the insulin pen in an upright position while priming to prime the pen prior to dialing the dose.Review of the manufacturer's instructions for Humalog pen revealed to prime the pen before each injection. Priming the pen meant removing the air from the needle and cartridge that may collect during normal use and ensured the pen was working properly. If you do not prime before each injection, you may get too much or too little insulin.Review of the manufacturer's instruction for Lantus solar pen revealed to attach the needle to the pen. Prime the pen by holding the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle to get the most accurate dose. Select the dose and inject subcutaneously.Review of the facility policy titled Safe Injection Practices dated 11/28/2017 revealed the policy did not address procedures to administer insulin by pen.