STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366484	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnstown Pointe Nursing & Rehabilitation Center	383 West Coshocton Street Johnstown, OH 43031

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on medical record review, observation, and staff interview, the facility failed to provide dignity in dining for one resident (Resident #60) of nine residents reviewed for dining observations. The facility census was 75. Review of the medical record for Resident #60 revealed an admitted [DATE]. Diagnoses included encounter for other orthopedic aftercare, anemia, difficulty in walking and need for assistance with personal care. Review of Resident #60's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. Review of Resident #60's nutrition care plan dated 11/27/24 revealed the resident was at risk of malnutrition related to his diagnoses, skin impairments, impaired vision, and a history of weight loss. A care plan intervention included to assist Resident #60 with his meals, including feeding him when needed. Observations on 12/31/24 from 8:27 A.M. to 8:30 A.M. revealed Certified Nursing Assistant (CNA) #157 was standing while feeding Resident #60 his lunch meal. CNA #157 was not observed to converse with the resident, rather was silently standing while simultaneously feeding Resident #60. Interview and observation with the Administrator on 12/31/24 at 8:30 A.M. confirmed that CNA #157 was standing while feeding Resident #60 his lunch meal. The Administrator confirmed CNA #157 was feeding Resident #60 in an undignified manner. The Administrator then approached CNA #157 and asked her to please sit as she continued to feed the resident, and CNA #157 obliged. Interview with Corporate Nurse #300 on 01/02/25 at 11:24 A.M. revealed the facility did not have a policy that addressed providing dignity while dining for residents.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on observation, interview, and record review, the facility failed to ensure pressure ulcer prevention interventions were implemented as ordered. This affected two (Residents #11 and #60) of two residents reviewed for pressure ulcers. The facility census was 75. Findings include: 1. Review of the medical record for Resident #11, revealed an admitted [DATE]. Diagnoses included but were not limited to anxiety disorder, Alzheimer's disease, unspecified dementia, restlessness and agitation, and chronic obstructive pulmonary disease. Review of Resident #11's Braden scale assessment completed on 11/13/24 revealed a score of 16, which indicated the resident was at risk for skin breakdown. Review of Resident #11's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 01 which indicated a severe cognitive impairment. The resident required supervision or touching assistance with bed mobility, and partial/moderate assistance with transfers, toileting, and bathing tasks. Resident #11 was assessed to be at risk for developing pressure ulcers/injuries. Review of the undated active care plan for Resident #11 revealed the resident was at risk for alteration in skin integrity related to altered circulation, incontinence, polypharmacy, and impaired mobility. Listed interventions included a low air loss mattress. Review of physician's order for Resident #11 revealed an order dated 11/22/24 for a low air loss mattress to bed with raised perimeters. The order called for settings per resident comfort and to check placement and function every shift and as needed. Review of Resident #11's most recent weight revealed on 12/05/24, the resident weighed 108 pounds. Observation on 12/30/24 at 8:27 A.M. revealed Resident #11 was in bed and lying on a low air loss mattress. The mattress had adjustable settings and controls and was set for a patient weight of 250 pounds. A subsequent observation on 12/31/24 at 8:16 A.M. revealed Resident #11 was again lying in bed with the low air loss mattress setting set for a patient weight of 250 pounds, unchanged from prior observation. Interview on 12/31/24 at 8:20 A.M. with the Director of Nursing (DON) confirmed Resident #11's low air loss mattress was incorrectly set to 250 pounds, when the resident weight was only 108 pounds. 2. Review of the medical record for Resident #60, revealed an admitted [DATE]. Diagnoses included but were not limited to displaced intertrochanteric fracture of right femur, encounter for other orthopedic aftercare, anemia, difficulty in walking and need for assistance with personal care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #60's Braden scale assessment completed on 12/06/24 revealed a score of 15, which indicated the resident was at risk for skin breakdown. Review of Resident #60's MDS 3.0 assessment dated [DATE] revealed a BIMS score of 11 which indicated moderately impaired cognition. The resident was assessed to require partial/moderate assistance with bed mobility and substantial/maximum assistance with toileting, bathing, and transfers. Resident #60 was assessed to be at risk for developing pressure ulcers/injuries and to have a stage 3 pressure ulcer that was not present upon admission. Review of the undated active care plan for Resident #60 revealed the resident was at risk for alteration in skin integrity related to diabetes, incontinence, and mobility impairments. A listed intervention included to maintain a low air loss mattress to the bed. Review of Resident #60's physician's orders revealed an order dated 12/09/24 for a low air loss mattress to bed with raised perimeters. The order called for settings per resident comfort and to check placement and function every shift and as needed. Review of Resident #60's most recent weight revealed on 12/30/24, the resident weighed 154.2 pounds. Observation on 12/30/24 at 8:33 A.M. revealed Resident #60 was lying in bed with a low air loss mattress in place. The mattress had adjustable settings and controls and was set for a patient weight of 220 pounds. A subsequent observation on 12/31/24 at 8:17 A.M. revealed Resident #60 was again lying in bed with the low air loss mattress setting set for a patient weight of 220 pounds, unchanged from prior observation. Interview on 12/31/24 at 8:21 A.M. with the DON confirmed Resident #60's low air loss mattress was incorrectly set to 220 pounds, when the resident weight was only 154.2 pounds.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to ensure resident weights were timely obtained to confirm and address significant weight loss. This affected one (Resident #120) of three residents reviewed for nutrition. The facility census was 75. Findings include: Review of the medical record for Resident #120 revealed the resident was admitted to the facility on [DATE]. Medical diagnoses included anemia, myocardial infarction, difficulty walking, chronic obstructive pulmonary disease, moderate protein calorie malnutrition, insomnia, chronic kidney disease (stage III), major depressive disorder, hyperlipidemia, and alcohol abuse. Review of Resident #120 weights revealed he was allegedly weighed on 12/13/24, where it was reported he weighed 188.2 pounds. Review of Resident #120 hospital discharge records, dated 12/13/24, revealed his weight being 188 pounds and 15 ounces. Review of Resident #120 progress notes, dated 12/13/24 to 12/20/24, revealed he was discharged from the facility on 12/14/24 for a complication with his shoulder wound. He was readmitted back to the facility on [DATE]. Review of Resident #120 weights revealed he was not weighed after his readmission to the facility until 12/23/24, which was over seven days from his last weight, and four days after being readmitted to the facility from the hospital. His weight was documented as 169.2 pounds, which was a 10.1% decline from his initial admission weight on 12/13/24. Review of Resident #120 weights revealed a re-weight was taken on 12/27/24, which revealed his weight being 158.4 pounds. This reflected another 6.4% decline from his weight on 12/23/24, and a total decline since 12/13/24 of 15.8%. Review of Resident #120 nutritional assessment, dated 12/20/24, revealed the full assessment using his weight of 188.2 pounds as the basis of the assessment. He was already on a nutritional supplement, but there was no documentation of a weight loss or concern or weight loss during this assessment. Review of Resident #120 physician/nutritional orders revealed an order dated 12/26/24 for House Supplement (nutritional drink) 120 cubic centimeter (cc) twice daily and an order dated 12/28/24 for mirtazapine (an antidepressant that can have appetite-stimulating effects) 7.5 milligrams (mg) at bed time for weight loss. Review of Resident #120 progress notes, dated 12/30/24, confirmed both weight entries on 12/23/24 and 12/27/24 identified a significant weight loss. Resident #120's record indicated nursing staff reported the significant weight loss to the physician, but not until 12/27/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Dietitian #301 on 12/31/24 at 10:54 A.M. confirmed there was a significant amount of weight loss since admission for Resident #120. She confirmed his hospital documentation found he weighed 188 pounds; she did not obtain the admission weight so she is not sure if it was completed in the facility or if staff recorded the resident's weight from his hospital records. When asked if that was a question she asked while investigating the weight loss, Dietician #301 did not answer the question. When asked if she had concerns that the weights were not taken every seven days when first admitted , Dietician #301 stated again that she wasn't in the facility, so she didn't take the weights and declined to answer the question. Interview with Director of Nursing (DON) on 1231/24 at 12:11 P.M. and 1:30 P.M. confirmed they do weekly weights for four weeks, and then the physician/dietitian decide how often weights will be taken after that. She initially stated she was not confident Resident #120 weight was taken in the facility on 12/13/24, but taken from the hospital discharge records. The DON later confirmed she spoke with the admitting nurse and they did take Resident #120's admission weight from the hospital discharge records. The DON confirmed they could not confirm what the resident's actual admitting weight was on 12/13/24, and if there was an actual significant weight decline. The DON additionally confirmed the facility should have re-weighed Resident #120 when he returned back to the facility from the hospital on 12/19/24, but the weight was not obtained until 12/23/24. Review of the policy Weight Monitoring, dated 02/15/24, revealed based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preference indicate otherwise. Newly admitted residents weight will be monitored as close to weekly as possible for the initial four weeks, and at least monthly thereafter. Significant changes in weight are reported to the practitioner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few 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** 47569 Based on observations, medical record reviews, staff interviews, and facility policy review the facility failed to implement Enhanced Barrier Precautions (EBP) for one resident with an indwelling urinary catheter, and one resident with an unhealed surgical wound related to a fractured hip. This deficient practice affected two residents (Resident #220 and #269) out of four residents reviewed for Enhanced Barrier Precautions. The facility census was 75. Findings include: 1. A review of Resident #220's medical record revealed an admitted [DATE] with diagnoses including but not limited to dementia, high blood pressure, neuromuscular dysfunction of bladder, and chronic pain syndrome. Resident #220 had impaired cognition with a Brief Interview Mental Status (BIMS) score dated 12/24/24 of two out 15 total score and required assistance from staff to complete Activities of Daily Living (ADL) task completion. A review of Resident #220's signed physician orders revealed an order dated 12/17/24 for use of a 16 French Indwelling Foley Catheter with 30 milliliters (ML) balloon to straight drain related to neuromuscular dysfunction of bladder every shift, and an order dated 12/18/24 for Enhanced Barrier Precautions (EBP) related to Foley Catheter every shift. Further review of Resident #220 Treatment Administration Record (TAR) dated 12/17/24 to 12/31/24 revealed order for EBP related to Foley Catheter every shift was marked as completed per shift twice daily. A review of Resident #220's risk for infection care plan dated 12/19/24 revealed Resident #220 was at risk for infection related to the indwelling urinary catheter with interventions including Enhanced Barrier Precautions (EBP). An observation on 12/30/24 at 10:45 A.M. revealed Resident #220 with an indwelling urinary catheter in place. Resident #220 resided in a dual-occupancy room. There were no personal protective equipment (PPE), including gowns, available. Additionally, there was no sign visible for staff and visitors to wear PPE during direct care and or assistance for Resident #220. An interview on 12/30/24 at 10:46 A.M. with Licensed Practical Nurse (LPN) #190 confirmed Resident #220 did not have any PPE available for use and there was no visual reminder of EBP to alert staff or visitors to use PPE during direct care activities. An interview on 12/31/24 at 8:18 A.M. with the Director of Nursing (DON) confirmed when a resident has an indwelling urinary catheter EBP should be implemented, PPE should be available for use by staff and visitors, and there should be a visual reminder for PPE use in place. 47987 2. Review of the medical record for Resident #269 revealed an admitted [DATE]. Diagnoses included but were not limited to displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, repeated falls, encounter for other orthopedic aftercare, and need for assistance with personal care. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #269's care plan, initiated on 12/27/24, revealed alteration in skin integrity as evidence by surgical areas (wounds) present to the resident's left him and left thigh. The care plan made no mention of EBP being utilized or required. Review of Resident #269's active physician's orders revealed an order dated 12/31/24 for surgical wound care. The order called for staff to cleanse with normal saline and cover with bordered gauze dressing daily and as needed until resolved. Subsequent review of Resident #269's physician's orders revealed no order for enhanced barrier precautions. Observation on 01/02/24 at 10:07 A.M. with Unit Manager Registered Nurse (UM RN) #136 revealed Resident #269's dressings to the left superior and left inferior thigh surgical sites were completed per orders. During the observation, UM RN #136 wore gloves but did not wear a gown during the dressing change. Interview on 01/02/24 at 10:17 A.M. with UM RN #136 confirmed she did not wear a gown for enhanced barrier precautions as Resident #269 was not identified to require enhanced barrier precautions. UM RN #136 believed the only complicated surgical wounds required the use of enhanced barrier precautions and stated Resident #269's surgical wounds were not complicated. Interview on 01/02/24 at 10:33 A.M. with Registered Nurse (RN) #166 verified Resident #269 was not identified to require enhanced barrier precautions. Review of the Center for Medicare & Medicaid Services Enhanced Barrier Precautions in Nursing Homes memorandum dated 03/20/24 revealed enhanced barrier precautions are to be implemented for unhealed surgical wounds. EBP are used in conjunction with standard precautions and calls for gloves and gown to be worn during high-contact resident care activities. Wound care for any skin opening requiring a dressing is considered a high-contact resident care activity.