STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366179	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solon Pointe at Emerald Ridge	5625 Emerald Ridge Parkway Solon, OH 44139

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 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 observation, medical record review, hospital document review, review of fall investigations, resident representative interview, staff interview, and policy review, the facility failed to ensure resident care plans were revised to reflect residents' current medical and psychological status and resident representatives were provided the option to chose care and treatment interventions during care plan development. This affected two (#22 and #82) of twenty-two sampled residents. The facility census was 92.Findings include:1. Review of Resident #22's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type; dementia with psychotic disturbance; and cognitive communication deficit. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact, required hands-on assistance for activities of daily living, and had no documented behaviors. Review of Resident #22's care plan dated 07/05/24 revealed the resident had behavior problems as evidenced by: traveling to vending machines and purchasing items regardless of diet; smearing feces in his room and throughout the facility; preferring to wear women's clothing and have nails painted; refusing to allow staff to organize personal items; hanging soiled clothing on heaters, in the shower, and over his wheelchair; refusing housekeeping services; embellishing stories about money and credit cards; and stating he carries ten credit cards at all times. Review of Resident #22's January 2026 physician orders revealed an order dated 06/10/24 to monitor behaviors every shift. Review of Resident #22's medication administration record (MAR) revealed Resident #22 had zero documented behaviors during November and December 2025 and January 2026. Despite the absence of any documented behaviors for at least three months, Resident #22's care plan continued to list extensive behavioral concerns without revision or reassessment. Social Service Director (SSD) #701 confirmed during an interview on 01/08/26 at 8:45 A.M. that Resident #22's care plan had not been updated to reflect his current behavioral status. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated 03/01/22, revealed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #82 revealed he was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, intracranial injury, post traumatic seizures, and spastic quadriplegic cerebral palsy. Review of the MDS assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 00, that indicated Resident #82 had severe cognition impairment. Review of the MDS assessment revealed Resident #82 was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 05/19/25 revealed Resident #82 had increased risk for falls and an actual fall related to brain injury with interventions that included ensure a safe environment and anticipation to meet the needs of the resident. Further review of the care plan included additional interventions in keeping call light within reach, handrails on the wall, and bed in lowest position at night. Review of the admission hospital paperwork dated 05/12/25 revealed Resident #82 had a history of traumatic brain injury secondary to a gunshot wound, status post right hemicraniectomy with elective right cranioplasty. The resident was wheelchair bound with a seizure disorder and weak in all extremities. Review of the hospital paperwork revealed Resident #82 was a fall risk and required a bed alarm. Review of the fall risk assessment dated [DATE] revealed Resident #82 was a high risk for falls. Review of the admission care conference dated 05/21/25 at 11:00 A.M. revealed Resident #82 had poor safety awareness related to falls and/or fall risk and was dependent for all care. Review of the care conference dated 07/01/25 at 11:13 A.M. revealed Resident #82 was dependent on staff for ADLs. Review of the care conference revealed Resident #82's fall risk was not discussed. Review of the fall risk assessment dated [DATE] revealed Resident #82 had a history of one to two falls within the last six months. Review of the progress notes dated 08/14/25 at 12:31 A.M. revealed Resident #82 had an unwitnessed fall around 12:30 A.M. Registered Nurse (RN) #925 heard a sound that led to Resident #82's room, where he was found with his head down on the right side of his bed with his legs still in the bed. Resident #82 was repositioned in bed and placed back on the ventilator with his oxygen level at 55 percent (%) that increased to 95% less than a minute after. Resident #82, at approximately 12:45 A.M., had an episode of projectile vomiting and was subsequently sent out to the hospital via emergency medical services (EMS) due to his history of right intracranial surgery and presenting symptoms. Review of the fall follow-up assessment dated [DATE] at 12:38 A.M. revealed Resident #82 had a fall with no signs and/or symptoms of bleeding or bruising and fall mats put into place as the new intervention and was effective. Review of the hospital after-visit summary, dated 08/14/25 at 5:39 A.M., revealed Resident #82 was seen in the emergency department for a fall and was subsequently diagnosed with a fall with a head injury (struck left side of the head). Review of the after-visit summary revealed Resident #82 was a high risk for falling upon discharge. Review of the progress note dated 08/14/25 at 8:32 A.M. revealed Resident #82 experienced an (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unwitnessed fall. Resident #82 fall interventions were put into place. Review of the post fall/incident investigation summary dated 08/14/25, with no time indicated, revealed Resident #82 was observed at bedside, was assessed for range of motion and vital signs were within normal limits. Resident #82's physician and Power of Attorney (POA) were notified, and the fall protocol was followed. Review of the document revealed prior interventions were in place and current interventions consisted of repositioning, neurological checks, and put in place extended bed and extended air mattress. Further review of the document revealed Resident #82 contributing factors leading to the fall included poor bed mobility, decreased safety, and epilepsy. Review of the document revealed Resident #82 had a history of seizure activity, loss of trunk control, impaired posture stability, decreased safety awareness resulting in him sliding out of bed and inability to self-correct or recognize the need for assistance. Review of the document revealed no prior or subsequent implementation of floor mats. Observation on 01/05/26 at 8:30 A.M., 10:45 A.M., 12:15 P.M., and 2:00 P.M. revealed Resident #82 in bed with no fall mats observed in place. Resident #82 was observed to only be able to follow the surveyor with his eyes and slightly shift position of his head. Resident #82 appeared to lack voluntary control of his body. Observation and interview on 01/06/26 at 9:03 A.M. revealed Resident #82 lying in bed with no floor mats in place. Licensed Practical Nurse (LPN) #839 stated Resident #82 was fully dependent on staff for ADLs, was a fall risk, and was required to be checked on every two hours. LPN #839 stated Resident #82 never had fall mats in place as a fall intervention. LPN #839 revealed Resident #82's POA visited frequently and spoke to staff about his care needs. LPN #839 revealed the resident's POA asked about fall mats, but LPN #839 stated, Fall mats are not needed because he cannot move on his own. LPN #839 confirmed and verified the above findings at the time of the interview. Interview on 01/06/26 at 9:10 A.M. with Certified Nurse Aide (CNA) #745 revealed Resident #82 was a fall risk. CNA #745 revealed Resident #82 utilized a special high-back wheelchair to decrease his risk of falls while out of bed. CNA #745 revealed Resident #82 did not have floor mats in place to decrease the risk of injury if he fell out of bed. CNA #745 revealed Resident #82's POA visited him in the facility, wanted fall mats implemented, and had plans on discharging him home. CNA #745 revealed Resident #82's bed, during the day, was in the highest position, but she had never seen it in the lowest position. CNA #745 revealed Resident #82 had a history of seizures that could result in uncontrollable body movements. CNA #745 confirmed and verified Resident #82 did not have floor mats in place and was still a fall risk despite being unable to control his body movements. Interview on 01/07/26 at 1:54 P.M. with Medical Doctor (MD) #926 revealed Resident #82 was at high risk for falls due to his history of rolling out of bed. MD #926 revealed Resident #82 did not communicate well, had severe cognition deficits, and if he was high risk for falls, floor mats were typically an option for intervention. Interview on 01/08/26 at 10:47 A.M. with the Director of Nursing (DON) revealed Resident #82 was admitted to the hospital after a fall and identified as a fall risk due to his medical diagnoses. The DON revealed all residents were assessed for fall risk upon admission and information provided from other sources was taken into consideration. The DON revealed prior to Resident #82's fall, there were no fall mats in place, and after his fall, she implemented an extended bed as a result of the fall. The DON revealed she did not put floor mats in place as she felt it was not needed as a result of her assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/08/26 at 3:08 P.M. with Resident #82's POA revealed the resident was completely dependent on staff for all ADLs. The POA revealed Resident #82 was unable to care for himself and had a history of seizures which resulted in him being a high fall risk. The POA revealed prior to admission to the facility, Resident #82 had a history of sliding out of bed, seizures, and that she informed the facility staff upon admission. The POA revealed she requested fall mats to be placed down as a safety precaution due to his history of a gunshot wound to the head, traumatic brain surgery, and his falls out of bed. The POA revealed Resident #82 sustained a fall out of bed and hit his head that resulted in swelling, bruising, and scratches to his face. The POA revealed after multiple requests, the facility staff refused to put fall mats in place. The POA revealed she was currently planning to discharge Resident #82 home. Review of the facility policy titled, Comprehensive Person-Centered Care Plans, revised March 2022, revealed the interdisciplinary team in conjunction with the resident and/or his family or legal representative developed and implemented a care plan for each resident. Review of the policy revealed each resident and/or representative had a right to participate and request meetings and revisions to the plan of care. This deficiency represents non-compliance investigated under Complaint Number 2597600.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, hospital document review, review of fall investigations, resident representative interview, staff interview, and policy review, the facility failed to ensure appropriate fall interventions were implemented and consistently in place to prevent falls. This affected one (#82) of three residents reviewed for falls. The facility census was 92.Findings include:Review of the medical record for Resident #82 revealed he was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, intracranial injury, post traumatic seizures, and spastic quadriplegic cerebral palsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 00, that indicated Resident #82 had severe cognition impairment. Review of the MDS assessment revealed Resident #82 was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 05/19/25 revealed Resident #82 had increased risk for falls and an actual fall related to brain injury with interventions that included ensure a safe environment and anticipation to meet the needs of the resident. Further review of the care plan included additional interventions in keeping call light within reach, handrails on the wall, and bed in lowest position at night. Review of the admission hospital paperwork dated 05/12/25 revealed Resident #82 had a history of traumatic brain injury secondary to a gunshot wound, status post right hemicraniectomy with elective right cranioplasty. The resident was wheelchair bound with a seizure disorder and weak in all extremities. Review of the hospital paperwork revealed Resident #82 was a fall risk and required a bed alarm. Review of the fall risk assessment dated [DATE] revealed Resident #82 was a high risk for falls. Review of the admission care conference dated 05/21/25 at 11:00 A.M. revealed Resident #82 had poor safety awareness related to falls and/or fall risk and was dependent for all care. Review of the fall risk assessment dated [DATE] revealed Resident #82 had a history of one to two falls within the last six months. Review of the progress notes dated 08/14/25 at 12:31 A.M. revealed Resident #82 had an unwitnessed fall around 12:30 A.M. Registered Nurse (RN) #925 heard a sound that led to Resident #82's room, where he was found with his head down on the right side of his bed with his legs still in the bed. Resident #82 was repositioned in bed and placed back on the ventilator with his oxygen level at 55 percent (%) that increased to 95% less than a minute after. Resident #82, at approximately 12:45 A.M., had an episode of projectile vomiting and was subsequently sent out to the hospital via emergency medical services (EMS) due to his history of right intracranial surgery and presenting symptoms. Review of the fall follow-up assessment dated [DATE] at 12:38 A.M. revealed Resident #82 had a fall with no signs and/or symptoms of bleeding or bruising and fall mats put into place as the new intervention and was effective. Review of the hospital after-visit summary, dated 08/14/25 at 5:39 A.M., revealed Resident #82 was seen in the emergency department for a fall and was subsequently diagnosed with a fall with a head injury (struck left side of the head). Review of the after-visit summary revealed Resident #82 was a high risk for falling upon discharge. Review of the progress note dated 08/14/25 at 8:32 A.M. revealed Resident #82 experienced an unwitnessed fall. Resident #82 fall interventions were put into place. Review of the post fall/incident investigation summary dated 08/14/25, with no time indicated, revealed Resident #82 was observed at bedside, was assessed for range of motion and vital signs were within normal limits. Resident #82's physician and Power of Attorney (POA) were notified, and the fall protocol was followed. Review of the document revealed prior interventions were in place and current interventions consisted of repositioning, neurological checks, and put in place extended bed and extended air mattress. Further review of the document revealed Resident #82 contributing factors leading to the fall included poor (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed mobility, decreased safety, and epilepsy. Review of the document revealed Resident #82 had a history of seizure activity, loss of trunk control, impaired posture stability, decreased safety awareness resulting in him sliding out of bed and inability to self-correct or recognize the need for assistance. Review of the document revealed no prior or subsequent implementation of floor mats. Observation on 01/05/26 at 8:30 A.M., 10:45 A.M., 12:15 P.M., and 2:00 P.M. revealed Resident #82 in bed with no fall mats observed in place. Resident #82 was observed to only be able to follow the surveyor with his eyes and slightly shift position of his head. Resident #82 appeared to lack voluntary control of his body. Observation and interview on 01/06/26 at 9:03 A.M. revealed Resident #82 lying in bed with no floor mats in place. Licensed Practical Nurse (LPN) #839 stated Resident #82 was fully dependent on staff for ADLs, was a fall risk, and was required to be checked on every two hours. LPN #839 stated Resident #82 never had fall mats in place as a fall intervention and confirmed the above findings at the time of the interview. Interview on 01/06/26 at 9:10 A.M. with Certified Nurse Aide (CNA) #745 revealed Resident #82 was a fall risk. CNA #745 revealed Resident #82 utilized a special high-back wheelchair to decrease his risk of falls while out of bed. CNA #745 revealed Resident #82 did not have floor mats in place to decrease the risk of injury if he fell out of bed. CNA #745 revealed Resident #82's bed, during the day, was in the highest position, but she had never seen it in the lowest position. CNA #745 revealed Resident #82 had a history of seizures that could result in uncontrollable body movements. CNA #745 confirmed and verified Resident #82 did not have floor mats in place and was still a fall risk despite being unable to control his body movements. Interview on 01/08/26 at 10:47 A.M. with the Director of Nursing (DON) revealed Resident #82 was admitted to the hospital after a fall and identified as a fall risk due to his medical diagnoses. The DON revealed all residents were assessed for fall risk upon admission and information provided from other sources was taken into consideration. The DON revealed prior to Resident #82's fall, there were no fall mats in place, and after his fall, she implemented an extended bed as a result of the fall. The DON revealed she did not put floor mats in place as she felt it was not needed as a result of her assessment. Review of the facility document titled, Managing Falls and Fall Risk, revised December 2007, revealed that based on previous evaluations and current data staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and minimize complications from falling. The staff will monitor and document each resident's response to interventions intended to reduce falling or risk of falling. This deficiency represents non-compliance investigated under Complaint Number 2597600.