

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2024
NAME OF PROVIDER OR SUPPLIER  Divine Rehabilitation and Nursing at Canal Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE  145 Olive St Akron, OH 44310	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</b></p> <p>Based on observation, interview, and facility policy review the facility failed to ensure all medications were disposed of in a safe and secure manner. This had the potential to affect an unidentified number of staff and 46 residents (#1, #4, #9, #10, #17, #18, #19, #20, #22, #23, #25, #27, #28, #30, #32, #35, #38, #39, #40, #49, #50, #51, #52, #55, #56, #59, #60, #65, #66, #67, #70, #73, #74, #75, #76, #77, #80, #81, #82, #84, #89, #90, #94, #97, #99, and #100) residing on the third floor of the facility who potentially could have accessed the unsecured medications. The facility census was 101.</p> <p>Findings include:</p> <p>Observation on [DATE] at 1:05 P.M. of the medication room on the third-floor revealed a large sharps disposal container on the counter that was approximately one quarter of the way full of an array of multiple different medications. There was no lid on the sharps container.</p> <p>Interview on [DATE] at 1:10 P.M. with Registered Nurse (RN) #709 verified there was a large sharps disposal container in the third-floor medication room on the counter without a lid on it, and it was one quarter of the way full of an array of multiple different medications. She stated the container was not secure. This was how they destroyed medications for residents who were discharged , or medications that were discontinued. She stated there was no fluid for the destruction of the medications, so they just keep putting the medications in sharps container.</p> <p>Interview on [DATE] at 1:20 P.M. with Licensed Practical Nurse (LPN) #10 confirmed there was a large sharps disposal container in the third-floor medication room on the counter without a lid on it, and it was one quarter of the way full of an array of multiple different medications. She stated the container was not secure. This was how they destroyed medications for residents who were discharged , or medications that were discontinued. She stated there was no fluid for the destruction of the medications, so they just keep putting the medications in sharps container.</p> <p>Interview on [DATE] at 3:30 P.M. with the Director of Nursing (DON) revealed the facility was out of the liquid used to destroy medications and they would order more from the pharmacy and destroy the medications when it arrived. The DON stated the facility had a policy for the destruction of medications; however, the policy was not provided when requested.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2024
NAME OF PROVIDER OR SUPPLIER  Divine Rehabilitation and Nursing at Canal Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE  145 Olive St Akron, OH 44310	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the undated Medication Administration policy revealed no information regarding destruction of expired or discontinued medications.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153460.</p>