STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365696	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Forest Hill	100 Reservoir Road St Clairsville, OH 43950

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 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0757 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, emergency medical service and hospital record review, interview, policy review and review of nursing standards of practice, the facility failed to ensure Resident #58 was free of unnecessary medication without adequate monitoring. This affected one (#58) of three residents reviewed for medication errors. The facility census was 61. Actual Harm occurred on 10/26/25 when Resident #58, a resident with a known low heart rate requiring cardiovascular medications to be held due (due to low heart rate) was administered four cardiovascular medications resulting in the resident becoming unresponsive one hour after medication administration. Resident #58 was transported to the emergency room by ambulance, where she was treated with intravenous fluids for hypotension (low blood pressure) a result of the medication administration. Prior to the administration of the medications, the facility failed to implement systems to ensure blood pressure monitoring was completed to prevent medication complications/adverse outcomes. Findings include:Review of the medical record for Resident #58 revealed an admission date of 08/20/20. Resident #58 had diagnoses including non-ST elevation myocardial infarction; dysphagia following cerebral infarction; essential hypertension; difficulty in walking, dysphagia; cognitive communication deficit, muscle wasting and atrophy, anxiety disorder, altered mental status and diverticulitis.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating the resident was cognitively intact. A plan of care plan dated 08/27/25 revealed a focus of care for altered cardiovascular status due to a history of a non-ST elevation myocardial infarction (heart attack). Interventions included giving medications as ordered, monitoring side effects, monitoring vital signs as ordered/per protocol and notifying the physician of any significant abnormalities, which included rapid pulse, shallow, rapid or labored respirations, and low blood pressure.Review of the vital sign records for Resident #58, dated 10/25/25 at 9:40 P.M., revealed the resident had a pulse of 57 beats per minute (normal heart rate is considered 60-100 beats per minute). The resident's blood pressure was not assessed. Review of a progress note for Resident #58 dated 10/25/25 at 9:40 P.M. revealed Metoprolol Tartrate (a drug indicated for treatment of high blood pressure), ordered twice daily for the resident, with parameters to hold the medication if the pulse was less than 60, was held. The medication was held (at this time) due to the low pulse.Review of the vital sign records for Resident #58 dated 10/26/25 at 7:56 A.M., revealed a pulse of 70 beats per minute. The resident's blood pressure was not assessed at this time. Review of the Medication Administration Record (MAR) dated 10/26/25 revealed the resident was ordered and administered the following cardiovascular medications for blood pressure management during morning medication pass:Isosorbide Mononitrate ER (extended release) 60 milligrams (mg) by mouth, Amlodipine Besylate 10 mg one tablet by mouth, Metoprolol Tartrate 25 mg one tablet by mouth twice daily for hypertension and Lisinopril 20 mg one tablet. The medication order for the Metoprolol revealed to hold the medication if the resident's heart rate was less than 60. None of the medication orders included parameters for holding or administering the medication based on the resident's blood pressure.Review of a progress note dated 10/26/25 at 9:15 A.M. revealed the nurse was called to the resident's room by the Certified Nurse Aide. (CNA). The resident was sitting in her wheelchair with her head back, flaccid, not responding to voice commands or touch. The nurse sent the CNA to get another nurse. The residents' vital signs were taken. The resident had a change of mental status compared to baseline. The nurse practitioner (NP) was notified and 911 was called. Resident #58 was transferred to the hospital emergency room (ER) to be evaluated. Review of the vital sign record for Resident #58 dated 10/26/25 at 9:15 A.M., revealed the resident had a recorded pulse of 47 beats per minute and blood pressure of 110/60 documented. (Normal blood pressure is generally considered 120/80 millimeters of mercury (mm/Hg)).Review of Emergency Medical Transport documentation for Resident #58 dated 10/26/25 at 9:50 A.M., revealed the resident's heart rate was 73 and her blood pressure was 75/50 mm/Hg (hypotensive).Review of emergency room documentation for Resident #58 dated 10/26/25 revealed the resident arrived at the emergency room at 10:09 A.M., with a complaint of an unresponsive episode. At that time, her blood pressure was 83/50 and her heart rate was 69. At 11:56 A. M., the resident's blood pressure was 82/52 and her heart rate was 50. At 1:50 P.M., her blood pressure was 101/59, after administration of 1000 milliliters of normal saline intravenously at 12:16 P.M.Further review of the emergency room Record revealed the resident was discharged back to the facility with recommendation to have the primary care provider review the resident's blood pressure medications, which may have needed