STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366254	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Pointe Nursing & Rehabilitation	130 Buena Vista Street Baltic, OH 43804

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 Note: The nursing home is disputing this citation.	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** 34298 Based on observation, record review, and resident and staff interview, the facility failed to ensure the residents were treated with respect and dignity. This affected one (Resident #54) of one resident reviewed for respect and dignity. The facility census was 82. Findings include: Review of the medical record revealed Resident #54 was admitted on [DATE] with diagnoses including schizoaffective disorder, alcohol dependence with alcohol-induced persisting dementia, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 had cognitive impairment and behaviors which included hallucinations and delusions. Observation and interview on 05/27/25 at 12:29 P.M. revealed Certified Nursing Assistant (CNA) #276 standing at the doorway to the smoking room calling residents by name to enter the smoking room. Resident #54 was walking down the hall towards the smoking room. CNA #276 told Resident #54 to stop. Resident #54 kept walking and got close to CNA #276. CNA #276 leaned towards Resident #54 and in a raised voice told Resident #54 to go sit down until it was her turn. Resident #54 continued past CNA #276 and entered the smoking room. At 12:31 P.M., CNA #276 verified she had raised her voice and told Resident #54 to go sit down. CNA #276 stated Resident #54 raised her voice first and Resident #54 would push past other residents and had almost made several other residents fall before. That was why she told Resident #54 to sit down and wait her turn. At 12:32 P.M., Resident #54 was sitting in the smoke room and when asked if it bothered her that CNA #276 raised her voice and told Resident #54 to sit down, Resident #54 said it did. At 12:34 P.M., another resident (Resident #24) stated CNA #276 was not out of line because Resident #54 would just push her way through and would run into other people. Resident #24 stated CNA #276 was not abusive or disrespectful to any of the 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, review of the pre-admission screening and resident review (PASARR) assessment, and staff interview, the facility failed to implement specialized services as indicated in the PASARR level II outcome determination letter. This affected one (#50) of three residents reviewed for PASARR. The facility census was 82. Findings include: Medical record review revealed Resident #50 was admitted on [DATE] with diagnoses including schizoaffective bipolar type disorder, delusional disorder, panic disorder, auditory hallucinations, psychosis, suicidal ideations, depression, generalized anxiety, and insomnia. Review of the care plan: PASARR recommendations due to significant change dated 01/11/24 revealed interventions for interdisciplinary team to review the PASARR recommendations and follow recommendations as able or applicable. There was no evidence the other recommended services were added to the care plan after the PASARR determination letter was received approving Specialized Services on 02/03/25. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #50's PASARR level II conditions indicated there resident had a serious mental illness and had been discharged to an inpatient psychiatric facility. Review of the PASARR level II outcome report dated 02/03/25 revealed it was determined Resident #50 was appropriate for nursing facility services with approved Specialized Services. The following behavioral health services were required to be provided by the nursing facility including: a crisis intervention plan, a behavior management safety plan to decrease inappropriate behaviors and ensure safety, ongoing evaluation of the effectiveness of current psychotropic medication on target symptoms, ongoing medication review by a psychiatrist or similarly credentialed professional, mental health counseling, and a behaviorally based treatment plan. The reason for those services was to reduce mental health symptoms and provide supports. Other recommended services the resident would need to be provided by the certified nursing facility included but were not limited to : self-health care management training, activities of daily living (ADL) training, therapy evaluations, skills training, adaptive equipment evaluation, and structured therapeutic activities. The reason for the above supports was to promote health, wellness and independence. There was no evidence in Resident #50's medical record of a crisis intervention plan or behavior management safety plan as required or other recommendations as indicated in the PASARR determination letter dated 02/03/25. On 05/27/25 at 12:17 P.M., observation and interview revealed Resident #50 was laying in bed and refused to acknowledge Registered Nurse (RN) #215 or speak to the surveyor. RN #215 stated Resident #50 has not been receptive to staff and stated Resident #50 might need her medications adjusted. RN #215 stated Resident #50 was seen by the psychiatrist but did not know if the resident had a crisis plan. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/25 at 3:03 P.M., interview with Clinical Coordinator/Licensed Practical Nurse #271 verified there was no evidence the required PASARR services had been implemented after Resident #50 was approved for Specialized Services on 02/03/25. On 05/29/25 at 8:07 A.M., interview with Social Service Designee (SSD) #273 verified Resident #50's PASARR was approved with specialized services and these had not been addressed to date. On 05/29/25 at 9:40 A.M., interview with SSD #273 stated when he receives the PASARR Level II outcomes, he reviews the determination and then he was to update the care plan. SSD #273 notifies the clinical coordinator and physician to see if they want to order any of those services on the determination letter. SSD #273 stated he did not realize the behavioral health services and Specialized Services were required to be provided per the determination letter by the admitting nursing facility.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review, review of manufacturer guidelines and Medscape guidance, and staff interview, the facility failed to ensure their medication error rate did not exceed five percent (%). Nine errors occurred within 26 opportunities for an error rate of 34.6%. This affected three (#17, #62, and #72) of five residents observed for medication administration. The facility census was 82. Findings include: 1. Medical record review revealed Resident #17 was admitted on [DATE] with diagnoses including schizophrenia, paraplegia, congestive heart failure, and anxiety disorder. Review of Resident #17's physician orders dated May 2025 revealed to administer medications upon rising which included Aripiprazole (antipsychotic) 7.5 milligrams (mg). Review of the pharmacy pre-packaged pouch labeled At Rise for Resident #17 dated 05/27/25 revealed the pouch included Aripiprazole 7.5 mg with instructions 'Do Not Crush'. On 05/27/25 between 9:26 A.M. and 9:35 A.M., observation revealed Licensed Practical Nurse (LPN) #255 prepared Resident #17's medications including Aripiprazole and eight other medications. LPN #22 placed the nine medications into a plastic sleeve including the Aripiprazole and crushed the medications. LPN #255 put the crushed tablets in pudding and administered the medications to Resident #17. On 05/27/25 at 9:57 A.M., interview with LPN #255 verified she crushed Resident #17's Aripiprazole and the pharmacy instructions on the pre-packaged pouch indicated do not crush Aripiprazole. Review of Medscape guidance found at https://reference.medscape.com/drug/Abilify-maintena-aristada-aripiprazole-342983#11 revealed to swallow tablet whole; do not divide, crush, or chew. 2. Medical record review revealed Resident #72 was admitted on [DATE] with diagnoses including anxiety, Alzheimer's disease, hypertension and psychosis. Review of the physician orders dated May 2025 revealed to administer medications including tramadol (opioid), ativan (anxiety), benazepril (blood pressure), Colace (stool softener), famotidine (gastroesophageal reflex disease), Meloxicam (nonsteroidal anti-inflammatory), Miralax (stool softener), and lactulose liquid (stool softener). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/27/25 between 9:38 A.M. and 9:55 A.M., observation revealed Licensed Practical Nurse (LPN) #255 prepared Resident #72's At Rise medications including tramadol, ativan, benazepril, colace, famotidine and Meloxicam into a plastic sleeve, crushed the medications and put the crushed tablets in pudding. LPN #255 prepared Resident #72's Miralax in six ounces of water, lactulose liquid dose was poured into a glass of nutritional supplement and the above medications were taken to the lounge area where Resident #72 was seated in a specialty wheelchair. LPN #255 was observed scooping the crushed medications from the medication cup with a plastic spoon into Resident #72's mouth. The resident was observed to take the crushed medications in pudding that was heaping above the rim of the spoon; however, the bowl of the plastic spoon remained full of crushed medications and pudding. LPN #255 poured the liquid lactulose into the nutritional supplement and Resident #72 drank approximately five ounces of the nutritional supplement. The remaining doses of the crushed medications and liquid medications were all discarded in the trash. On 05/27/25 at 9:57 A.M., interview with LPN #255 verified the entire dose of crushed medications and liquid medication were not administered to Resident #72 and had been discarded in the trash. LPN #255 was unable to state which medications and how much of the medication was left in the pudding or nutritional supplement due to the medications were mixed together. 3. Medical record review revealed Resident #62 was admitted on [DATE] with diagnoses including congestive heart failure. Review of the physician orders dated May 2025 revealed to administer medications including Eliquis (anticoagulant), Lasix (diuretic), and Sacubitril-Valsartan (treats heart failure; also known as Entresto). On 05/28/25 at 3:30 P.M., observation of Resident #62's medication administration revealed Registered Nurse (RN) #281 placed Eliquis, Lasix and Sacubitril-Valsartan into a plastic sleeve, crushed the medication, put the crushed tablets in chocolate pudding and administered the medications to Resident #62. On 05/28/25 at 3:57 P.M., interview with RN #281 verified the above observation and stated the medications including Sacubitril-Valsartan were crushed because Resident #62 would chew the medications if not crushed. Review of the Novartis: Entresto manufacturer guidelines dated April 2024 does not recommend the splitting or crushing of Entresto. If you cannot swallow tablets, or if tablets are not available in the prescribed strength, you may take Entresto tablets prepared as a liquid (oral) suspension or may take Entresto sprinkle. Review of the policy titled Medication Administration dated 06/21/17 revealed medications were to be administered by legally-authorized and trained persons in accordance to applicable state, local and federal lows and consistent with accepted standards of practice.