

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Emerald Pointe Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Michelli Street Barnesville, OH 43713	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923</p> <p>Based on record review, review of a medication error report and the facility's related investigation, resident interview, staff interview, review of employee personnel files, and policy review, the facility failed to have competent nurse staffing to ensure medications were administered to residents to meet professional standards of nursing. This affected two residents (#41 and #44) of four residents reviewed.</p> <p>Findings include:</p> <p>1 a.) Review of Resident #44's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included congestive heart failure (CHF), chronic ischemic heart disease, hypertension (HTN), and atrial fibrillation.</p> <p>Review of Resident #44's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was not known to have displayed any behaviors or reject care during the seven days of the assessment period.</p> <p>Review of Resident #44's physician's orders revealed she received the following cardiac related medications: Digoxin 250 micrograms (mcg) by mouth (po) every day; Diltiazem HCL 60 milligrams (mg) po three times a day for HTN; Isosorbide Mononitrate 60 mg po once daily for angina; Metoprolol Tartrate 25 mg po twice a day for HTN.</p> <p>Review of Resident #44's medication administration record (MAR's) for February 2024 revealed she received the following medication the morning of 02/07/24: Eliquis 5 mg po, Aspirin (ASA) 81 mg po, B-12 1,000 mcg po, Digoxin 250 mcg po, Diltiazem HCL 60 mg po, Isosorbide Mononitrate 60 mg po, Jardiance 10 mg po, Levothyroxine Sodium 88 mcg po, Loratadine 10 mg po, Metformin 1000 mg po, Metoprolol Tartrate 25 mg po, Miralax 17 Grams po, Protonix 40 mg po, and UTI Stat 30 ml po. All medications were signed off as having been given by Registered Nurse (RN) #100.</p> <p>Review of Resident #44's progress notes revealed a nurse's note dated 02/07/24 at 11:37 A.M. that revealed the resident was awake and alert. She denied any problems or discomforts at that time. She was seated in her chair at the bedside. She stated her blood pressure was being monitored by the nurse. She was aware of receiving medications that morning. Her physician was updated regarding medication clarification and medications taken that morning and her vital signs. No new orders were given at that time. They planned to continue to monitor the resident.</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
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident #44's progress notes revealed a nurse's note dated 02/07/24 at 6:50 P.M. that indicated the nurse updated the physician that the resident's blood pressure just reached 100/51 mm/hg. The nurse continued to monitor the resident all day and she had been asymptomatic with her blood pressure slowly rising. The physician gave a verbal order to send the resident to the emergency room , if her BP went below 100 systolic or she became symptomatic.</p> <p>Review of Resident #44's blood pressures recorded under the vital sign tab of the electronic medical record (EMR) revealed the following blood pressure readings: 02/07/24 at 10:31 A.M.- 98/53; 02/07/24 at 11:12 A.M. - 98/51; 02/07/24 at 12:28 P.M.- 87/55; 02/07/24 at 2:42 P.M.- 81/43; 02/07/24 at 6:46 P.M.- 100/51.</p> <p>1 b.) Review of Resident #41's EMR revealed she was admitted to the facility on [DATE]. Her diagnoses included atrial fibrillation, CHF, HTN, chronic ischemic heart disease, atherosclerotic heart disease, and schizo-affective disorder.</p> <p>Review of Resident #41's quarterly MDS assessment dated [DATE] revealed she had no communication issues and was cognitively intact. She was not known to have displayed any behaviors or reject care during the seven day assessment period.</p> <p>Review of Resident #41's MAR's for February 2024 revealed the resident was due to receive the following po medications the morning of 02/07/24: Apixaban 5 mg po, Carafate 1 Gm po, Lasix 80 mg po, Januvia 100 mg po, Jardiance 25 mg po, Lactulose 15 ml po, Linzess 145 mcg po, Lisinopril 20 mg po, Loratadine 10 mg po, Metformin 1000 mg po, Metoprolol Succinate ER 50 mg po, Nexium 40 mg po, Senna Plus 8.6 mg-50 mg po, and Synthroid 137 mcg po. The medication administration times when those medications were given were for 6:00 A.M. or rising. All of the above medications were signed off as having been given by RN #100.</p> <p>Review of the facility's medication error report from 01/01/24 through 05/21/24 revealed they only had one medication error incident that allegedly occurred during that time period. Resident #44 was identified as being the resident involved.</p> <p>Review of the incident report for the alleged medication error for Resident #44 revealed it was dated for 02/07/24 at 6:00 A.M. The facility's Director of Nursing (DON) was the one who completed the medication error report. Information provided on the medication error report indicated the resident with the same last name with rooms across from each other. They were sisters who requested to be across the hall from one another. Notes included as part of the medication error report indicated the DON was informed of a possible medication error by the day shift nurse. They monitored the resident's blood pressure and pulse frequently. The resident had no complaints, concerns, or discomforts. Her daily routine by the resident was indicated to be as per her usual. Her appetite had been good and she was taking fluids well. The physician was notified of the possible medication error. Nurses were interviewed and voiced no medications were administered wrongly. The intervention added was all residents with the same last name were identified with alerts added to medication carts to identify such.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's related investigation into the alleged medication error involving Resident #44 revealed statements were obtained from RN #100 and RN #225. RN #100's statement dated 02/07/24 indicated, while passing morning medications on the 300 hall, she took Resident #41's medications to her. Resident #41 only wanted her Carafate and Synthroid at that time. Another nurse assisting her with the medication pass administered Resident #44's medications. RN #100 indicated she returned Resident #41's medicine cup in Resident #44's slot in the medication administration cart in error.</p> <p>RN #225's written statement indicated during the 4:00 A.M. medication pass, he had pulled Resident #44's medications out from the medication administration cart and administered medication to the resident on 02/07/24.</p> <p>Further review of the facility's investigation into the alleged medication error revealed it included interview notes from the DON with conversations she had with RN #100, RN #225, and RN #300. The interview notes with RN #300 revealed the nurse was concerned Resident #41's morning medications were in a cup in Resident #44's slot in the medication administration cart. She reported her concerns to Human Resources, who in turn, notified the DON. The DON interviewed RN #100 and was told she gave Resident #41's Carafate and Synthroid. The rest had been placed back into the drawer of the medication cart. The DON's interview with RN #225 indicated he gave all of Resident #41's medications to her. The DON's interview with Resident #41 indicated she got her thyroid medication and her stomach medication. The DON's interview with Resident #41 indicated she got all of her medications. A second page of interview notes with RN #100 revealed the medications placed in Resident #44's slot in the medication cart by the night shift nurse were the ones the day shift nurse saw in the wrong slot and was unsure about the medications. The DON indicated in her notes that she had verbally educated both night shift nurses on the need to destroy opened/ not taken medications as opposed to returning them to the medication administration cart and only to sign off medications that they have administered.</p> <p>On 05/21/24 at 12:25 P.M., an interview with Resident #44 (while she was visiting with Resident #41) revealed she suspected she was given the wrong medication, which was intended for her sister, the morning of 02/07/24. The medication she thought she had received in error included blood pressure medication. She claimed she did not take any blood pressure medications herself, despite her having HTN and medications ordered to treat HTN. She claimed she was informed she received her sister's blood pressure medication, but was not sure what other medications she may have been given along with it. Resident #41 added that she took Metoprolol for her blood pressure. Resident #44 indicated it was a new male nurse that gave it to her. She was not sure of his name, but when the male nurse's name was mentioned she stated yes that was it. Resident #44 also stated the male nurse did not sign off on her being given her medications and another nurse signed it off instead. She reported as a result of getting that medication, her blood pressure was low. She was not sure how low it got, but they were worried about it. She claimed she felt lightheaded, dizzy, and weak after she was given that medication (not supported by the nurses' progress notes). She reported the facility was very secretive about the whole situation.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/21/24 at 1:48 P.M., an interview with RN #100 revealed she was the nurse that worked on 02/07/24, when the alleged medication error occurred. She stated she was the night shift nurse that night and it was at the end of the shift. She was helping with the end of the medication pass on the 300 hall. She was not familiar with the residents over there, as she was normally in the office. She pulled the medications for Resident #41 and went to give them to her. Resident #41 only wanted to take a couple of them at that time. She did not want all of her medications at once and only took her Synthroid and the Carafate. The remaining medications were in a plastic medicine cup and taken back to cart. She had a nurse with her helping pass the medications (RN #225). He was working nights with her and she instructed him to go ahead and give Resident #41's medications to her. She stated she handed him the medications to give to Resident #41, after she had pulled them from the medication cart. She admitted she had placed Resident #41's medications back into the medication cart under Resident #44's slot. She denied that Resident #44 was given the wrong medication. She gave report to the day shift nurse and informed her that Resident #41 only took a couple of her morning medications. The day shift nurse assumed Resident #44 received Resident #41's medications due to Resident #41's medications erroneously being put in Resident #44's slot in the top drawer of the medication cart. They monitored Resident #44 following that as a precaution. She reported they were not supposed to sign off on a resident's medications if they were not the one who gave them. She confirmed she had done that that night as it was a crazy night and they were behind in their medication pass. She signed off Resident #44's medications the morning of 02/07/24, despite RN #225 being the one who gave them. She also signed off all of Resident #41's day shift medications, even though she only gave the Carafate and Synthroid and her other morning medications were given by the day shift nurse. She could not recall if she signed the medications off ahead of time or not. She denied they had been given by the day shift nurse at the time she signed the eMAR to reflect they had been given.</p> <p>On 05/21/24 at 2:26 P.M., an interview with the DON/ Administrator revealed they were not able to determine Resident #44 received the wrong medications that was ordered for Resident #41. Resident #41's medications were allegedly returned to the medication cart, when she did not take them all. The DON denied that she checked the medications that had been returned to the medication cart to see what they were or which resident they belonged to. She did not try to determine if they were Resident #41's to rule out Resident #44 being given them by mistake. She just disposed of them as they should not have been returned to the medication cart, after they had been opened. She took the nurses word for it that Resident #44 was not given the wrong medications. She acknowledged Resident #44 had a drop in her blood pressure that was not her normal readings on 02/07/24, when the alleged error occurred. She stated Resident #44 had a lot of cardiac problems going on and she could not say for sure that her drop in blood pressure wasn't related to that. She also stated they were not regularly obtaining Resident #44's blood pressure to see if it had been running low prior to them checking it on 02/07/24. She reported both residents were on similar medications and both received similar medications for HTN. She was not concerned with the male nurse giving medications to a resident that he did not pull from the medication cart himself. She stated he was in the general area and likely observed what was going on. She acknowledged nurses were taught in nursing school to never administer medications to a resident that they did not prepare themselves. They were required to review the orders and verify the labels on medications when pulling them out of the medication cart to verify the five rights of drug administration were followed.</p> <p>Attempted to interview RN #225 regarding the alleged medication error without success. Calls were placed on 05/21/24 at 4:36 P.M. and again on 05/22/24 at 10:06 A.M. with messages left on voicemail. A call back number was provided with each message, but no return call was received. The facility's DON reported he no longer worked at the facility and had taken a job elsewhere.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/22/24 at 10:10 A.M., a follow up interview with the facility's DON revealed, although she could not confirm whether a medication error occurred, she was able to identify concerns with RN #100 returning opened medications back to the medication administration cart when refused by a resident. She stated the nurse should have just went away and discarded the medications as they could not have an unlabeled medicine cup in the top of the medication cart where the medications could not be identified as to what they were or who they belonged to. She also identified concerns with a nurse signing off the MAR's to show medications had been administered, when she was not the nurse that gave them. She confirmed she provided education to the nurses about both those areas. Out of an abundance of caution, she also implemented an alert system in the medication cart when residents had the same last names. She did not want a similar situation to occur in the future, even though they could not prove either resident was given the wrong medications.</p> <p>On 05/22/24 at 10:48 A.M., a phone interview with RN #300 revealed she was the day shift nurse that worked on 02/07/24 and found Resident #41's medications in the wrong slot of the medication cart. She did not use them to give to the resident the morning of 02/07/24. She pulled the morning medications for the following day to be given to Resident #41 as hers that were left in the medicine cup in the top of the medication cart had been disposed of. She did not look at them closely enough to see for certain they were Resident #41's medications. She reported they were similar, but she could not say for certain that they were or weren't Resident #41's. She confirmed she monitored Resident #44's blood pressure throughout the day and it was low for the resident. She denied the resident reported any problems when she asked her if she was lightheaded, dizzy, or was having any chest pain. She denied she would ever administer medications to a resident that she did not pull out of the medication cart herself.</p> <p>Review of the employee personnel files for RN #100 and RN #225 revealed both nurses had active licenses. Both employees received education on medication pass procedures and five rights of drug administration as part of their orientation process. Their orientation checklist indicated the employee and their preceptor signed off to reflect both were reviewed upon hire. It did not include a competency check-off for medication administration, but the orientation checklist included a column to mark if additional training was being requested. The facility's DON confirmed new nurses were observed to administer medications as part of their orientation process and the employee and preceptor signed off when that had been completed.</p> <p>Review of the facility's Medication Administration policy (effective 06/21/17) revealed medications would be administered by legally-authorized and trained persons in accordance to applicable State, Local, and Federal laws consistent with accepted standards of practice. The procedure included the need for the nurse administering the medication to read the label comparing it to the MAR before preparing the medication. After the medication was given, the nurse was to return to the medication cart and document medication administration with initials on the MAR immediately after administering medication to each resident. Once removed from the package or container, unused doses should be destroyed following facility policy.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152938.</p>		