

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 03/03/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review and interview, the facility failed to ensure physician notification of a resident's blood pressure when outside of listed blood pressure parameters. This affected one resident (#27) of five residents reviewed for unnecessary medications. The census was 63.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including breast cancer, chronic kidney disease, cardiac murmur, atrial septal defect, hypertension, diabetes mellitus, renal insufficiency and urinary tract infection.</p> <p>Review of the nurse practitioner Nurse's Note dated 06/08/23 revealed to discontinue amlodipine 5 milligrams (mg) due to edema. Continue atenolol 50 (mg) and lisinopril 10 (mg) daily. Monitor blood pressure (BP) and consider increasing lisinopril if greater than (>) 130/80 mmHg with close monitoring of BMP. Continue atorvastatin 20 (mg) and will obtain echocardiogram due to murmur.</p> <p>Review of the cardiology advanced practice professional Progress Note dated 08/21/24 revealed Resident #27 was seen for routine follow-up evaluation for diagnoses including a murmur and essential hypertension. Orders included no discontinued medications and plan was to continue atenolol 50 (mg) and lisinopril 40 (mg) daily with a target blood pressure less than 130/80 mmHg.</p> <p>Review of the electronic Medication Administration Record (MAR) dated December 2024, January 2025 and February 2025 revealed a physician order to monitor BP/pulse every shift and as needed. The physician was to be notified if the resident's BP was greater than 130/80 mmHg with close monitoring of BMP.</p> <p>Review of the medical record revealed no evidence the physician was notified of the following BP readings greater than 130/80 as per order:</p> <p>On 12/02/24, night BP 146/82 with pulse of 62.</p> <p>On 12/13/24, day BP 134/86 with pulse 86.</p> <p>On 12/13/24, night BP 148/86 with pulse 62.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/14/24 , day BP 146/81 with pulse 73.</p> <p>On 12/14/24, night BP 132/84 with pulse 76.</p> <p>On 12/17/24 night BP 146/84 with pulse 60.</p> <p>On 12/21/24, night BP 136/84 with pulse 62.</p> <p>On 12/22/24,day BP 138/82 with pulse 82.</p> <p>On 12/22/24, night BP 140/84 with pulse 60.</p> <p>On 12/26/24, night BP 152/82 with pulse 66.</p> <p>On 01/13/25, night BP 140/84 with pulse 60.</p> <p>On 01/14/25, night BP 134/86 with pulse 62.</p> <p>On 01/16/25, day BP 158/92 with pulse 58.</p> <p>On 01/16/25, night BP 132/82 with pulse 62.</p> <p>On 01/26/25, day BP 138/88 with pulse 67.</p> <p>On 02/01/25, day BP 132/82 with pulse 54.</p> <p>On 02/05/25, day BP 140/86 with pulse 59.</p> <p>On 02/05/25, night BP 146/88 with pulse 63.</p> <p>On 02/14/25, night BP 173/82 with pulse 64.</p> <p>On 02/24/25, day BP 132/86 with pulse 65.</p> <p>On 02/26/25 at 5:27 P.M., interview with the Director of Nursing verified there was no evidence Resident #27's physician was notified of the above BP's exceeding the ordered parameters.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review and interview, the facility failed to develop comprehensive and individualized care plans. This affected one resident (#3) of two residents reviewed for Communication-Sensory concerns. The facility census was 63.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #3 was admitted on [DATE] with diagnoses including end-stage macular degeneration and cerebral infarction.</p> <p>Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact for daily decision-making, had highly impaired vision (object identification in question but eyes appear to follow objects) with corrective lenses and had obvious, likely cavities or broken natural teeth.</p> <p>Review of the Eye Care Chart Note dated 12/04/24 revealed the resident complained of right eye poor vision for many years and glasses help the left eye a little. The resident's visual acuity of the right eye was 20/80 and his visual acuity of the left eye was 20/30.</p> <p>On 02/24/25 between 3:15 P.M. and 3:33 P.M., interview with Resident #3 revealed he cannot see out of one eye and has had the same glasses for a long time. Resident #3 stated the dietary/menu card print was too small to read and he could not see/read the card to choose what he would like to eat for the upcoming meals. Resident #3 stated it was frustrating and just picks without knowing what he was choosing. During the interview, Resident #3 was observed wearing glasses, his upper teeth and a lower tooth appeared decayed and in poor condition. Resident #3 stated his teeth bother him and he had seen a dentist before Christmas but they never did anything about his teeth and was told his teeth condition was too bad to get an implant.</p> <p>On 02/25/25 at 3:15 P.M., Resident #3 was observed wearing glasses while working on a puzzle.</p> <p>On 02/26/25 at 7:20 A.M., Resident #3 was observed sitting at a table in the main dining room wearing glasses. At 7:25 A.M., certified nurse aide (CNA) #242 was observed giving a meal card to Resident #3 for him to choose his meal options for lunch and dinner. Resident #3 was looking at the menu card without choosing any meal options. The surveyor asked Resident #3 what he was going to have for lunch and he stated he was unable to read the menu card as the print was too small and could not see what the menu options were. CNA #237 was observed walking past the resident's table and stopped to see if the resident was done filling out the menu card when Resident #3 stated he could not see the menu. CNA #237 stated she was unaware Resident #3 could not see the printed words on the menu card.</p> <p>On 02/27/25 at 12:59 P.M., interview with Social Services #216 verified Resident #3 did not have a individualized care plan for vision or dental.</p> <p>On 02/27/25 at 3:40 P.M., interview with Regional Director of Clinical Services #276 verified Resident #3 did not have a comprehensive vision or dental care plan.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on observation, resident council minute review, activity calendar review, medical record review and interview, the facility failed to provide a variety of activities to meet the interests of residents including evenings and weekends. This affected one resident (#3) of one resident reviewed for activities.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #3 was admitted on [DATE] with diagnoses including end-stage macular degeneration and cerebral infarction.</p> <p>Review of the admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #3 was cognitively intact for daily decision-making. Activity preferences included the following: it was very important to listen to music he liked and to go outside to get fresh air when the weather was good. It was somewhat important to have books, newspapers and magazines to read, be around pets, keep up the the news, do things with groups of people, to do favorite activities and participate in religious services or practices.</p> <p>Review of the admission 3.0 Activity Participation Review - V 4 dated 10/07/24 revealed Resident #3 was alert, would like to attend group activities of interest and will also pursue in room/independent activity. The resident's religious preference was Baptist, enjoyed playing euchre, bingo, listening to country music, bowling, fishing, the outdoors, watching some TV, cats and dogs and visits with family.</p> <p>Review of the care plan: Resident is a sociable person and likes to participate in a variety of activities dated 10/07/24 revealed Resident #3 enjoyed bingo, cards, country music, dog and cat visits, spending time outdoors, bowling and watching television/movies. Activity goals included will verbalize satisfaction with self-initiated, group or in room activities and will participate in activities of their choice through 04/06/25. Interventions included: provide verbal reminders of activity prior to commencement of activity, invite to music activities, invite to scheduled activities, provide activity schedule in room and remind he can leave an activity at any time.</p> <p>Review of the Activity Calendars revealed the following:</p> <p>a. October 2024 Activity Calendar revealed an evening activity at 6:00 P.M. on Mondays 10/07/24, 10/14/24, 10/21/24 and 10/28/24.</p> <p>b. December 2024 Activity Calendar revealed the following organized/scheduled activities:</p> <p>No organized/scheduled activities on Monday through Fridays after 2:00 P.M. except for Christmas carolers on 12/09/24 and 12/13/24.</p> <p>Weekend activities included the same three organized/scheduled activities:</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On Saturdays, Mingle in the Dining Room at 11:30 A.M. (visit with other residents in dining room while waiting on lunch to be served), Pokeno game at 1:30 P.M. and cards at 3:00 P.M</p> <p>On Sundays, Mingle in the Dining Room at 11:30 A.M., fingernail painting at 1:00 P.M. and resident choice/Church service at 2:00 P.M</p> <p>c. January 2025 Activity Calendar revealed the following organized/scheduled activities:</p> <p>No organized/scheduled activities on Monday through Fridays after 1:30 P.M. except for hot chocolate cart at 2:00 P.M. (Wednesdays) on 01/08/25, 01/15/25, 01/22/25 and 01/29/25.</p> <p>Weekend activities included the same three organized/scheduled activities:</p> <p>On Saturdays, Mingle in the Dining Room at 11:30 A.M., Pokeno game at 1:30 P.M. and cards at 3:00 P.M</p> <p>On Sundays, Mingle in the Dining Room at 11:30 A.M., fingernail painting at 1:00 P.M. and resident choice/Church service at 2:00 P.M</p> <p>d. February 2025 Activity Calendar revealed the following organized/scheduled activities:</p> <p>No organized/scheduled activities on Monday through Fridays after 1:30 P.M. except for hot chocolate cart at 2:00 P.M. (Wednesdays) on 02/05/25, 02/12/25, 02/19/25 and 02/26/25.</p> <p>Weekend activities included the same three organized/scheduled activities:</p> <p>On Saturdays, Mingle in the Dining Room at 11:30 A.M., Pokeno game at 1:30 P.M. and cards at 3:00 P.M</p> <p>On Sundays, Mingle in the Dining Room at 11:30 A.M., fingernail painting at 1:00 P.M. and resident choice/Church service at 2:00 P.M</p> <p>Review of Resident #3's individual Activity Participation record dated October 2024 through February 2025 included the following daily activities: television, reading, puzzles, visit with other residents/staff and wheeling/walking around. During November 2024, the resident had one visit from family/friends and one pet visit.</p> <p>On 02/24/25 between 3:15 P.M. and 3:33 P.M., interview with Resident #3 revealed he gets bored and was tired of doing puzzles all the time. Resident #3 stated he normally works with therapy in the mornings, goes to activities afterwards but there was nothing to do in the late afternoons or weekends. Resident #3 stated he has trouble seeing which limits activities he can do on his own and his family tries to visit when they can.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 02/25/25 at 10:44 A.M., observation revealed Activity Director #212 was pushing Resident #3 in a wheelchair up to a table in the kitchen area near the activity room. The resident was placed at a table by himself with a styrofoam cup and a single, prebaked cookie on a plate. The resident did not participate in the cookie baking activity and was positioned facing the wall. Female residents were observed sitting behind the resident at a rectangular table conversing with each other and they had already eaten their cookie. Review of the Activity Calendar dated February 2025 revealed Cooking Corner activity started at 10:00 A.M.</p> <p>On 02/25/25 at 3:15 P.M., the resident was observed in his room working on a puzzle. The resident's television was on. At 3:38 P.M., the resident was observed self propelling in the hallway to the dining room. Resident #3 stated he was going up to see if anything was going on in Activities before dinner. Review of the Activity Calendar dated February 2025 revealed no activities were scheduled after 1:30 P.M. on 02/25/25.</p> <p>On 02/26/25 at 10:33 A.M., Resident #3 was observed in his room. Resident #3 was asked if he was going to activities or if he was aware of the activity scheduled and he stated no. He asked what game it was and the resident stated he did not like to play the game Uno.</p> <p>On 02/26/25 at 1:34 P.M., Resident #3 was observed in the Main Dining Room listening to live music.</p> <p>On 02/27/25 at 12:08 P.M., interview with Activity Director #212 revealed Resident #3 likes bingo, party socials and appetizers, cooking corner, hot chocolate cart, eating meals in the dining room, music, completing puzzles in his room and watching westerns. Activity Director #212 states she used to have an evening activity but not many (one to two residents) were participating in the evening activity so she asked the residents at the Resident Council meeting dated 10/02/24 (review of the resident council meeting minutes revealed four residents attended the meeting in October 2024) if they could stop evening activities and they agreed; however, this was not discussed with all the residents and/or guardians. Prior to stopping evening activities, she had one evening activity aide until 7:00 P.M. on Mondays. Activity Director #212 stated she told residents by word of mouth that there would not be anymore activities in evening. Regarding weekend activities, she has one activity staff that works 12:00 P.M. until 4:00 P.M., they do a bingo, a card game or dice game and they also distribute the mail. Activity Director #212 verified the activities did not vary including weekends, and did not have activities after 1:30 P.M. or 2:00 P.M. during the week but was willing to try anything that interests the residents.</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on observation, consent review, medical record review and interview, the facility failed to ensure residents received proper treatment and assistive devices to maintain vision and hearing abilities. This affected two residents (Resident #3 and #18) of two residents reviewed for Communication-Sensory concerns. The facility census was 63.</p> <p>Findings include:</p> <p>1. Medical record review revealed Resident #3 was admitted on [DATE] with diagnoses including end-stage macular degeneration and cerebral infarction.</p> <p>Review of the Dental Consent dated 09/30/24 revealed the resident consented to have ancillary services including vision and dental.</p> <p>Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact for daily decision-making, had highly impaired vision (object identification in question but eyes appear to follow objects) with corrective lenses.</p> <p>Review of the Eye Care Chart Note dated 12/04/24 revealed the resident complained of right eye poor vision for many years and glasses help the left eye a little. The resident's visual acuity of the right eye was 20/80 and his visual acuity of the left eye was 20/30.</p> <p>There was no evidence Resident #3 was assessed or received new glasses or a prescription for new glasses to help increase his visual acuity.</p> <p>On 02/24/25 between 3:15 P.M. and 3:33 P.M., interview with Resident #3 stated he cannot see out of one eye and has had the same glasses for a long time. Resident #3 stated the dietary/menu card print was too small to read and he could not see/read the card to choose what he would like to eat for the upcoming meals. Resident #3 stated it was frustrating and just picks without knowing what he was choosing. During the interview, Resident #3 was observed wearing glasses.</p> <p>On 02/25/25 at 3:15 P.M., Resident #3 was observed wearing glasses while working on a puzzle.</p> <p>On 02/26/25 at 7:20 A.M., Resident #3 was observed sitting at a table in the main dining room wearing glasses. At 7:25 A.M., certified nurse aide (CNA) #242 was observed giving a meal card to Resident #3 for him to choose his meal options for lunch and dinner. Resident #3 was looking at the menu card without choosing any meal options. The surveyor asked Resident #3 what he was going to have for lunch and he stated he was unable to read the menu card as the print was too small and could not see what the menu options were. CNA #237 was observed walking past the resident's table and stopped to see if the resident was done filling out the menu card when Resident #3 stated he could not see the menu. CNA #237 stated she was unaware Resident #3 could not see the printed words on the menu card.</p> <p>2. Medical record review revealed Resident #18 was admitted on [DATE] with diagnoses including Parkinson's disease, generalized anxiety disorder, atrial fibrillation, bradycardia, dependence on renal dialysis and cardiomegaly.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the care plan: Impaired Vision dated 03/19/23 revealed requires glasses for optimal vision. Interventions included to encourage glasses to be worn as needed. Ensure eyeglasses are clean, appropriate and being worn by resident and schedule eye exam as necessary.</p> <p>Review of the Eye Care Chart Note dated 12/14/23 revealed six month retinal evaluation for vessel changes both eyes, no pain or double vision. Resident #18 was becoming bothered by vision in the right eye and wanted to have the cataract removed. The cataract was visually significant with changes in retinal vascular appearance bilateral. Retinal vascular attenuation and atherosclerosis was also present. We will monitor, order ERG (electroretinography) testing and a dilated fundus exam. Review of the medical record revealed no evidence a dilated fundus exam or ERG (measures the electrical activity of the retina, the light-sensitive layer of the eye) had been completed to date as recommended.</p> <p>Review of the annual MDS assessment dated [DATE] revealed the resident had impaired vision (sees large print, but not regular print in newspapers/books) and did not use corrective lenses.</p> <p>On 02/26/25 at 11:18 A.M. and 12:50 P.M., interview with Social Services #216 verified Resident #18 had not seen the optometrist due to her cataract surgery being rescheduled three times over the course of 2024. Currently the resident's cataract surgery was not scheduled until May 2025 and there had been no follow-up as recommended for a dilated fundus exam or new eyeglasses to date.</p> <p>On 02/26/25 at 12:55 P.M., observation and interview with Resident #18 revealed she was sitting in her room and was not wearing glasses. A black eyeglass case was observed on the nightstand next to the resident and when asked if she wore her glasses the resident stated she has not been able to use her glasses because they don't work and cannot see out of them. The resident stated she does try to use them to read sometimes. The resident went on to state it is horrible, I can't see, I can't hear, it is horrible.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on medical record review and interviews the facility failed to ensure identification, assessment, and appropriate interventions were put in place to achieve [NAME] bowel function for Resident #13, Resident #46, and Resident #51. This affected three residents (#13, #46, and #51) out of four residents reviewed for bowel and bladder. Facility census was 63.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #13 was admitted on [DATE] with diagnoses of metabolic encephalopathy, asthma, cognitive communication, acute kidney failure, chronic kidney disease stage 4, and urinary retention.</p> <p>A care plan dated 11/07/24 revealed Resident #13 was at risk for constipation. Interventions included to administer medication as ordered and monitor for constipation and causes.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #13 was cognitively intact, occasionally incontinent of urine and always continent of bowel. Resident #13 required substantial/maximal assistance for toilet hygiene and partial/moderate assistance for toilet transfer.</p> <p>Review of the bowel elimination documentation revealed Resident #13 had a bowel movement on 02/14/25. The bowel elimination documentation from 02/15/25 to 02/25/25 revealed Resident #13 did not have a bowel movement. The next bowel elimination documentation was on 02/26/25.</p> <p>Review of the medication administration record (MAR) revealed on 02/16/25 Resident #13 was administered Bisacodyl enteric-coated delayed release (laxative) five milligrams. The Bisacodyl was effective. Further review of the MAR revealed no other medication being administered to help facilitate a bowel movement.</p> <p>Interview on 02/26/25 at 12:42 P.M. the Director of Nursing (DON) verified the facility did not have a bowel protocol in place and did not use standing orders for medications to help facilitate a bowel movement. The DON verified if a resident did not have a bowel movement for three days, the physician should be notified and orders obtained as needed.</p> <p>An additional interview on 02/26/25 at 2:17 P.M. the DON verified there was no documentation of Resident #13 having a bowel movement from 02/17/25 through 02/25/25.</p> <p>2. Review of the medical record revealed Resident #46 was admitted on [DATE] with diagnoses that included normal pressure hydrocephalus, dysphagia, Alzheimer's disease, chronic kidney disease, anxiety, and acute kidney failure.</p> <p>A care plan dated 08/14/24 revealed Resident #46 was at risk for constipation. Interventions included to administer medications as ordered and to monitor for constipation and causes.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 5-day MDS dated [DATE] revealed Resident #46 had cognitive impairment and was always incontinent of bowel and bladder.</p> <p>Review of the bowel elimination documentation from 02/15/25 to 02/18/25 revealed Resident #46 did not have a bowel movement. Resident #46 had a bowel movement on 02/19/25 and 02/22/25. The bowel elimination documentation from 02/23/25 to 02/27/25 revealed Resident #46 did not have a bowel movement.</p> <p>Review of the MAR for February 2025 revealed no evidence of Resident #46 being administered medication to help facilitate a bowel movement.</p> <p>Interview on 02/26/25 at 12:42 P.M. the Director of Nursing (DON) verified the facility did not have a bowel protocol in place and did not use standing orders for medications to help facilitate a bowel movement. The DON verified if a resident did not have a bowel movement for three days, the physician should be notified and orders obtained as needed.</p> <p>An additional interview on 02/27/25 at 1:42 P.M. the DON verified there was no documentation of Resident #46 having a bowel movement from 02/15/25 through 02/18/25 and 02/23/25 through 02/27/25.</p> <p>51519</p> <p>3. Record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including dementia, Alzheimer's, muscle weakness, thyrotoxicosis, osteoporosis, glaucoma, constipation, anxiety, vitamin D deficiency, and major depressive disorder.</p> <p>Review of the Minimum data set (MDS) completed on 01/29/25 revealed Resident #51 had a brief interview for mental status (BIMS) score 00, which indicated cognitive impairment. The MDS also revealed Resident #51 had bowel continence, required substantial/maximal assistance for toileting, and had a history of constipation.</p> <p>Record review of Resident #51 task for bowel assessment revealed no documentation of a bowel movement (BM) on 02/13/25, 02/14/25, 02/15/25, or 02/16/25.</p> <p>Record review of Resident #51 task for bowel assessment revealed no documentation of a bowel movement on 02/23/25, 02/24/25, 02/25/25, 02/26/25.</p> <p>Record review of Resident #51 medication administration record (MAR) and treatment administration record (TAR) for February 2025 revealed no documentation Resident #51 had received interventions to assist in a bowel movement.</p> <p>Record Review of Resident #51's care plan dated 02/11/25 revealed Resident #51 was at risk for constipation related to decreased mobility, medication use, malnutrition, and a history of constipation. Interventions included monitoring for constipation.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Emerald Pointe Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Michelli Street Barnesville, OH 43713	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/24/25 11:20 A.M. resident representative for Resident #51 stated that Resident #51 did have issues with constipation. Family representative stated she will ask staff if Resident #51 has had a bowel movement but she was not sure how honest staff are being. Resident #51's representative was not sure if Resident #51 had been getting any laxatives' or stool softeners to assist in relieving bowels.</p> <p>Interview on 02/26/25 at 12:43 P.M. with the Director of Nursing (DON) revealed implementation of interventions to promote bowel movements would depend on the residents but the expectation is around day two to three (with no bowel movement) they would begin to investigate the issue. She stated the nurses on the floor monitor frequency of bowel movements on their shift. A nurse or certified nursing assistant (CNA) should document if the resident has had a bowel movement and communicate information in report. It should flag on the dashboard of the electronic medical record (EMR) if someone has not had a bowel movement in a certain number of days. It should be communicated in report from shift to shift if the resident has had a BM or not; there is no record or protocol it is just the expectation. The DON stated the nurse would need to call the doctor for a stool softener or laxative because there was no standing orders. The DON confirmed Resident #51 had gone four days with no bowel movement, no identification of no bowel movement by staff, and no interventions implemented.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review and interview, the facility failed to ensure a resident did not receive unnecessary medication when a resident was administered antibiotics not at the ordered dose. This affected one resident (#27) of five residents reviewed for unnecessary medications. The census was 63.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including breast cancer, chronic kidney disease, cardiac murmur, atrial septal defect, hypertension, diabetes mellitus, renal insufficiency and urinary tract infection.</p> <p>Review of the Progress Note dated 02/06/25 revealed facility had received a call from Resident #27's urology office stating the urinalysis done at their office showed the resident had an UTI. The physician office sent in an order for Bactrim DS (antibiotic) twice a day to be administered for 10 days. A Physician order was written and the antibiotic was started on 02/07/25 and administered through 02/17/25.</p> <p>Review of the electronic Medication Administration Record dated February 2025 revealed Resident #27 received 21 doses of Bactrim DS instead of the ordered 20 doses.</p> <p>On 02/27/25 at: 10:45 A.M., interview with Director of Nursing verified the resident was only ordered to receive two doses a day for 10 days.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765</p> <p>Based on observation, review of the medical record, and interview with staff revealed the facility failed to ensure safe storage of medications. This affected one resident (#7) of five residents reviewed for accidents.</p> <p>Finding included:</p> <p>Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included fracture of the T5 and T6 vertebra, fracture of one rib, ankylosing spondylitis of the thoracic, acute respiratory failure, muscle weakness, dysphagia, pneumonia, hemothorax, atrial fibrillation, congestive heart failure, generalized anxiety disorder, peripheral vascular, hyperglycemia, gout, vertigo, osteoarthritis, chronic pain syndrome, chronic rhinitis, major depressive disorder, hypertension, hypothyroidism, insomnia and a pacemaker.</p> <p>Review of the Quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #7 had intact cognition.</p> <p>Review of the February 2025 physician's order revealed Resident #7 had an order for Fluticasone Propionate Nasal Suspension 50 micrograms, one spray in both nostrils once daily. Resident #7 did not have an order to self administration or have nasal spray at bedside.</p> <p>Observation on 02/24/25 at 4:35 P.M. revealed she had a bottle of Fluticasone propionate nasal spray on top of her refrigerator in her room</p> <p>Observation on 02/25/25 at 9:50 A.M. revealed she had a bottle of Fluticasone propionate nasal spray on top of her refrigerator in her room.</p> <p>On 02/25/25 at 9:50 A.M. an interview with Licensed Practical Nurse #224 confirmed Resident #7 had a bottle to Fluticasone propionate nasal in her room. She verified Resident #7 did not have an order to self administer or to have her Fluticasone propionate nasal spray at bedside.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review and interview, the facility failed to ensure a resident's nephrologist was notified of abnormal laboratory results. This affected one resident (#27) of five residents reviewed for unnecessary medications. The census was 63.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including breast cancer, chronic kidney disease, cardiac murmur, atrial septal defect, hypertension, diabetes mellitus, renal insufficiency and urinary tract infection.</p> <p>Review of the Comprehensive Metabolic Panel dated 07/26/24 revealed BUN (blood urea nitrogen) was 28 (normal 7-17 mg/dL), creatinine 1.40 (normal 0.5-1.0 mg/dL), BUN/Crea ratio was 20 (normal was 6-20) and estimated GFR was 41 (normal >60 mL/min/L).</p> <p>Physician #279 ordered to follow-up with Resident #27's renal physician (nephrologist) regarding the above lab results.</p> <p>Review of the Comprehensive Metabolic Panel dated 01/02/25 revealed abnormal laboratory findings including: BUN was 37 (normal 7-17 mg/dL), creatinine was 1.44 (normal 0.5-1.0 mg/dL), BUN/Crea ratio was 26 (normal was 6-20), estimated GFR was 40 (normal >60 mL/min/L), hemoglobin was 11.0 (normal 11.5-16.0 g/dL) and hematocrit was 34.3 (normal 34.8-46.0%).</p> <p>Physician #279 ordered to follow-up with Resident #27's renal physician regarding the above lab results.</p> <p>Review of the medical record revealed no evidence Resident #27's renal physician/nephrologist was notified of the above lab results on 07/26/24 or 01/02/25.</p> <p>Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact for daily decision-making, had no UTI in the last 30 days and was receiving a diuretic,</p> <p>On 02/27/25 at 10:17 A.M., interview with the Director of Nursing verified there was no evidence Resident #27's abnormal labs were reported to the nephrologist.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51519</p> <p>Based on medical record review, policy review and interview, the facility failed to ensure accurate and thorough medical records were maintained. This affected three residents (#13, #18, and #34) of 19 residents sampled. The census was 63.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including heart failure, anemia, coronary artery disease, atrial fibrillation, cellulitis, hypertension, diabetes mellitus, hyperlipidemia, arthritis.</p> <p>Record review of the minimum data set 3.0 (MDS) assessment completed on 01/20/25 revealed a brief interview for mental status score (BIMS) of 14, which indicated Resident #34 was cognitively intact.</p> <p>Record review of the MDS section N for medications completed on 01/30/25 revealed Resident #34 was on antibiotics.</p> <p>Record review revealed an order placed on 01/29/25 by the Medical Director for antibiotic oral capsule 500 milligram (mg) (Cephalexin) to be given 1 capsule by mouth two times a day for right hand cellulitis for eight days starting 01/29/25 with a stop date of 02/05/25.</p> <p>Record review of the medication administration record (MAR) revealed no documentation of Keflex 500 mg being administered on 02/04/25 for the evening dose.</p> <p>Interview on 02/25/25 at 10:23 A.M. with assistant director of nursing (ADON) verified Keflex was not documented as given on Tuesday 02/04/25 P.M. for dinner dose and progress note from 02/04/25 at 10:44 P. M. stated Resident #34 remained on antibiotic therapy with no adverse effects. No notes of the dose being missed/refused, no one notified of missing dose. No documentation of why the dose was not documented or a physician being notified of a missing dose.</p> <p>Review of medication administration policy 5.3 (effective 06/21/2017) the resident had the right to refuse medication. It is, however, the nurses responsibility to review with the resident the consequences of their refusal and document accordingly. If a medication is unavailable, contact the pharmacy and document accordingly. If a resident refuses medication, document on the medication administration record (MAR). Note refusal or ingestion of less than 100% of dose on the MAR in the designated area.</p> <p>2. Medical record review revealed Resident #13 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disorder (COPD), asthma, cognitive communication deficit, muscle weakness, acute kidney failure, chronic kidney disease stage four, pleural effusion, atrial fibrillation, generalized anxiety disorder.</p> <p>Medical record review of Resident #13's minimum data set (MDS) completed 1/24/25 revealed a brief interview for mental status (BIMS) score of 15.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical record review revealed an immunization consent form dated 01/07/25 Resident #13 consented to the Prevnar 20 Pneumococcal vaccine (PCV20).</p> <p>Medical record review revealed, an order placed on 01/14/25 by the Medical Director that ordered Prevnar 20 Suspension Prefilled Syringe 0.5 milliliter (ML) (Pneumococcal 20-[NAME] Conj Vacc) Inject 0.5 ml intramuscularly one time only for vaccine for 1 Day.</p> <p>Record review of Resident #13's medication administration record (MAR) for January of 2025 revealed no documentation the PCV20 vaccination had been administered to Resident #13.</p> <p>Interview on 02/27/25 at 1:23 P.M. with the ADON confirmed in point click care documentation is not on the MAR for the PCV20 immunization being administered. She stated she was not sure if something was wrong with their point click care but she was going to put in a work order.</p> <p>28704</p> <p>3. Medical record review revealed Resident #18 was admitted on [DATE] with diagnoses including atrial fibrillation, history of venous thrombosis/ embolism, end stage renal disease and dependence on renal dialysis.</p> <p>a. Review of the care plan: At Risk for Bleeding, Bruising, Abnormal Labs related to use of anticoagulant/thrombolytic medications initiated 06/01/23 revealed the resident was receiving coumadin (anticoagulant).</p> <p>Review of the electronic Physician Orders dated February 2025 revealed Resident #18 received apixaban (Eliquis) 5 milligrams twice a day. There was no evidence Resident #18 was receiving coumadin.</p> <p>b. Review of Resident #18's Kardex revealed the resident went to dialysis three times a week on Tuesday, Thursday and Saturday.</p> <p>On 02/26/25 at 12:48 P.M., interview with the Director of Nursing (DON) stated the resident dialysis days changed a long time ago due to transportation concerns and resident convenience. The DON verified the information in the Kardex was not accurate for dialysis scheduled days.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>2. Medical record review revealed Resident #27 was admitted on [DATE] with diagnoses including renal insufficiency, non-Alzheimer dementia and urinary tract infection (UTI).</p> <p>Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact for daily decision-making and had no UTI's in the last 30 days.</p> <p>Review of the Progress Note dated 02/06/25 revealed facility had received a call from Resident #27's urology office stating the urinalysis done at their office showed the resident had an UTI. The physician office sent in an order for Bactrim DS (antibiotic) twice a day to be administered for 10 days. Copies of laboratory results and progress note was requested. A Physician order was written and the antibiotic was started on 02/07/25 and administered through 02/17/25.</p> <p>Review of the electronic Medication Administration Record dated February 2025 revealed Resident #27 received 21 doses of Bactrim DS instead of the ordered 20 doses.</p> <p>Review of the medical record revealed no evidence the results of the urinalysis obtained on 02/04/25 or results of the urine culture was received between 02/06/25 and 02/17/25. On 02/27/25 at 8:09 A.M. Resident #27's Molecular Pathology Report (dated 02/05/25) was faxed to the facility revealing Streptococcus Agalactiae (Group B Strep) and Staphylococcus aureus (MRSA) had been detected and the microbial load was less than 100,000 CFU/mL with a potential resistance to Methicillin, carbapenems, cephalosporins, penicillins and beta-lactamase inhibitors was detected.</p> <p>Review of the record revealed the facility did not have the resident on any type of contact isolation precautions between 02/06/25 and 02/17/25.</p> <p>Review of the Minimum Criteria for Initiating Antibiotic Therapy form dated 02/07/25 revealed Resident #27 complained of urgency and frequency. No other symptoms were documented. Date of infection was 02/06/25 when order received for antibiotic. There was no documentation of the organism or determination if an infection criteria was met.</p> <p>On 02/27/25 at 9:52 A.M., interview with Assistant Director of Nursing (ADON) #200 verified the facility had not received the urinalysis/pathogens detected report from the urologist until today and verified contact isolation should have been initiated for MRSA/Group B Strep urine results.</p> <p>On 02/27/25 at 10:45 A.M., interview with Director of Nursing verified facility requested the urine culture but had not received result until after requested by the surveyor and the resident was only ordered to receive two doses a day for 10 days.</p> <p>35765</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, review of the medical record and interview with staff the facility failed to appropriately monitor a resident experiencing signs and symptoms of a contagious respiratory illness and failed to implement contact isolation precautions for a resident with an infectious microorganism in the urine. This affected one resident (#21) of two residents reviewed for respiratory care and one resident (#27) of three residents reviewed for antibiotic usage.</p> <p>Findings included:</p> <p>1. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE]. Diagnoses chronic obstructive pulmonary disease, diabetes, asthma, acute respiratory failure, schizophrenia, psychosis, hypertension, fibromyalgia, sleep apnea, migraine, generalized anxiety disorder, peripheral vascular disease, and insomnia.</p> <p>Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #21 had intact cognition and refused the influenza vaccine.</p> <p>Review of the February Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no documentation Resident #21's temperature was monitored from 02/20/25 to 02/25/25.</p> <p>Review of the vital signs, including temperature, documented in Point Click Care revealed the last documented temperature for Resident #21 was on 02/19/25 at 98 degrees Fahrenheit.</p> <p>Review of the February 2025 physician's orders revealed Resident #21 had an order for Allegra 180 milligrams at bedtime for cold symptoms and nasal congestion dated 02/20/25</p> <p>Review of the health status note dated 02/20/25 at 6:43 P.M. revealed Resident #21 complained of sinus congestion and cold symptoms. The Physician was updated and a new order was received for Allegra once a day for seven days. The resident was afebrile, lungs were clear, skin was warm, dry and flesh tone.</p> <p>There was no documentation regarding the resident's respiratory status (lung sounds, cold symptoms), including temperature, on 02/21/25.</p> <p>Review of the health status note dated 02/22/25 at 6:23 A.M. revealed Resident #21 complained of continued sinus congestion, dizziness, cough. Her vital signs were temperature 98.0 degrees Fahrenheit, oxygen saturation was 96 percent on room air, lungs were clear, respiration were 18 and her blood pressure was 122/70. She continues on Allegra at bedtime for sinus congestion.</p> <p>There was no documentation regarding the resident's respiratory status (lung sounds, cold symptoms), including temperature, on 02/23/25.</p> <p>There was no evidence Resident #21 was tested for COVID or influenza even though she exhibited signs and symptoms of a respiratory illness that could be contagious to others.</p> <p>On 02/24/25 at 8:55 A.M. an interview with Resident #21 revealed she felt like she was getting the flu. She stated she was coughing, had nasal congestion, was having some nausea but no vomiting or diarrhea.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 02/24/25 at 11:15 A.M. revealed Resident #21 was out in the dining room sitting. The resident was not wearing a mask.</p> <p>Observation on 02/25/25 at 10:20 A.M. revealed Resident #21 was out in the dining room for an activity. The resident was not wearing a mask.</p> <p>On 02/26/25 at 1:15 P.M. an interview with Director of Nursing (DON) indicated she would expect the staff to monitor and take the temperature routinely for a resident experiencing respiratory signs and symptoms to make sure they were not getting worse.</p> <p>On 02/27/25 at 2:21 P.M. an interview with Regional Director of Clinical Services #27 indicated they should assess the resident, monitor, and if symptoms continue they would test for COVID. She stated they were doing a respiratory assessment however there was a glitch and the temperature section was never added so they were never done.</p> <p>On 02/27/25 at 2:31 P.M. an interview with the DON confirmed there was no monitoring from the first signs of flu like symptoms 02/20/25 to 02/22/25 then from 02/22/25 to 02/26/25.</p> <p>Review of the Centers for Disease Control website, Testing and Management Considerations for Nursing Home Resident with Acute Respiratory Illness Symptoms when SARS_CoV-2 and influenza Viruses are Co-circulating (dated 11/14/23) revealed you could not tell the difference between flu and COVID-19 by symptoms alone because many signs and symptoms are the same. Testing was needed to confirm a diagnoses. Signs and Symptoms of both COVID-19 and flu included fever but not everyone with the flu would have a fever, cough, shortness of breath, fatigue, sore throat, runny or stuffy nose, muscle pains, headache, vomiting , diarrhea and change in or loss of taste and smell.</p> <p>Review of the facility policy titled, Infection Control-Infection Surveillance, (dated 11/28/17) revealed the system of surveillance was utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. Nurses participate in surveillance thorough assessment of resident and reporting changes in condition to the resident's physicians and management staff.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298</p> <p>Based on record review and interview the facility failed to ensure antibiotics were not ordered without meeting the required criteria for Resident #32. This affected one resident (#32) of three residents reviewed for antibiotic use. Facility census was 63.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #32 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included chronic kidney disease, hydronephrosis, neuromuscular dysfunction of bladder, type 2 DM, urinary tract infection, acute kidney failure with tubular necrosis, and paraplegia.</p> <p>A care plan dated 08/09/24 revealed Resident #32 was at risk for infection related to suprapubic catheter, type 2 diabetes, and urinary retention. Interventions included to administer antibiotics as ordered and monitor of signs and symptoms of a urinary tract infection.</p> <p>A health status note dated 12/23/24 at 3:22 A.M. revealed Resident #32 reported testicle pain. Resident #32 reported he usually had a urinary tract infection when he felt testicle pain. Resident #32 requested his urine to be checked. A urine test strip, used as a basic diagnostic tool to determine pathological changes, was positive. An order was received for urinalysis.</p> <p>Urine results faxed to the facility on [DATE] revealed Resident #32's urine was abnormal with moderate leukocytes and blood, and was positive for nitrites.</p> <p>A health status note dated 12/23/24 at 4:20 P.M. revealed the facility physician was notified of urinalysis results. The facility physician instructed the nurse to contact Resident #32's urologist.</p> <p>The infection control log revealed Resident #32 had onset of symptoms of testicle pain on 12/23/24 and chronic urinary tract infections. The urine results identified mixed flora. Cipro (antibiotic) 250 milligram (mg) was ordered twice a day for seven days by the urologist. The Loeb's minimum criteria (a set of clinical guidelines used to determine the need for antibiotic therapy in long-term care residents) form for initiating antibiotic therapy revealed no minimum criteria marked. A handwritten note on the form revealed Resident #32 had a history of chronic infections and complaints of testicular pain which was a usual sign of infection. A culture and sensitivity was done. The urologist was notified and ordered an antibiotic for Resident #32.</p> <p>A health status note date 12/24/24 at 12:10 P.M. revealed the urologist ordered Cipro for Resident #32.</p> <p>Review of the medication administration record (MAR) revealed Resident #32 was administered the first dose of Cipro the evening of 12/24/24.</p> <p>(continued on next page)</p>		

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 03/03/2025
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Urine culture results faxed to the facility on [DATE] revealed Resident #32's urine culture had mixed commensal flora. Mixed commensal flora in a urine sample is a mix of different bacteria that usually reside in the urinary tract without causing infection. This does not necessarily indicate a problem, and could be a sign of contamination during the sample collection.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #32 was cognitive intact.</p> <p>Interview on 02/26/25 at 10:12 A.M. Director of Nursing (DON) verified a culture and sensitivity was not completed due to urine results had mixed flora. The DON verified the use of Cipro did not meet the criteria and had been ordered by urologist.</p>		