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 _____	06/26/2025

name of provider or supplier	street address, city, state, zip code
CONTINUING HEALTHCARE AT FOREST HILL	100 RESERVOIR ROAD ST CLAIRSVILLE OH, 43950

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F 0000	INITIAL COMMENTS COMPLAINT INVESTIGATION COMPLAINT NUMBER OH00166414 ADMINISTRATOR: Carri Rejonis, #7414 CERTIFIED BED CAPACITY: 88 CENSUS IN HOUSE: 69 The following deficiencies are based on the complaint investigation completed on 06/26/25.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

TAMMIE.HOWELL | 07/11/2025

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F 0759	Continued From page 1	F 0759		
F 0759 SS=D	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This STANDARD is not met as evidenced by: Based on observation, record review, medication information review, policy review and interview, the facility failed to administer medication as ordered and/or in accordance with acceptable standards of practice. Three errors out of 28 opportunities were identified resulting in a 10.7% medication error rate. This affected one (Resident #5) of five residents observed for medication administration. Findings include: On 06/26/25 at 8:01 A.M., Licensed Practical Nurse (LPN) #100 was observed administering medication to Resident #5. Medications administered included two tablets of Potassium Chloride extended release (ER) 10 milliequivalents (meq) and one tablet of verapamil ER 240 milligrams (mg) (calcium channel blocker used to treat high blood pressure and angina). The tablets were crushed and added to other crushed medications. Review of Resident #5's physician orders revealed in addition to medication administered, Resident #5 had an order	F 0759	Resident #5 was assessed by RCS on 6/26/25 with no ill effects related to medications being crushed or missed vitamin administration. MD was notified with orders to change medications to crushable form and to discontinue the PreserVision AREDS as she was on a multivitamin with minerals on 6/26/25 by the floor nurse. By 7/14/25 all residents with need for medications to be crushed will be audited by RCS to ensure medications ordered were able to be crushed. Any negative findings will be addressed. By 7/14/25 an initial audit of all residents' medication administration records will be completed by RCS to ensure medications are administered as ordered. Any negative findings will be addressed. By 7/14/25, LPN #100 was educated by RCS related to crushing medications, forms that cannot be crushed, and administering all medications as ordered. All nurses will be educated by 7/14/25 by the DON or designee on medication administration to include crushing medications, medication that are not crushable, and administering all medications as ordered. Audit of 5 residents per week who require medications to be crushed will be completed weekly x 4 weeks by DON or designee to ensure medications ordered is allowed to be crushed. Medication pass observations will be conducted by the DON or designee for 5 nurses per week for 4 weeks to ensure proper medication administration. Any negative findings will be addressed immediately. DON or designee will complete med pass audits for 5 nurses per week x 4 weeks to ensure all medications are appropriately ordered and administered. DON	07/14/2025

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F 0759	Continued From page 2 for PreserVision AREDS (multivitamin with minerals) one tablet in the morning. On 06/26/25 at 8:03 A.M., LPN #100 verified she crushed extended release tablets of potassium chloride and verapamil, stating Resident #5 could not consume the pills whole. LPN #100 stated her understanding was Resident #5 crushed the pills for consumption at home also. LPN #100 was unaware if anybody had inquired of the physician if alternate forms of the drugs were available or if alternates would be more appropriate. At 8:38 A.M., LPN #100 stated after speaking to Resident #5 she was willing to try to take the extended release tablets without crushing them. At 11:34 A.M., LPN #100 verified she had not administered the PreserVision AREDS tablet as ordered, stating she had none available on the medication cart. At that time, she inquired of LPN #110 if she had any on her medication cart. On 06/26/25 at 1:25 P.M., Registered Nurse (RN) #120 verified extended release tablets were not generally supposed to be crushed. RN #120 provided a hospital inpatient swallowing discharge summary for service provided to Resident #5 on 01/03/25 which indicated Resident #5 was taking pills crushed in applesauce/pudding (if crushable). Review of medication information from Medscape revealed consideration should	F 0759	will be responsible for ongoing compliance. Results of audits will be reviewed at QAPI for adjustments as needed.	

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F 0759	Continued From page 3 be given to use liquid potassium if a resident had difficulty swallowing. Review of the verapamil extended release manufacturer guideline revealed tablets should be swallowed whole and not chewed, broken, or crushed. This deficiency represents non-compliance investigated under Complaint Number OH00166414.	F 0759		

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F 0760	Continued From page 4	F 0760		
F 0760 SS=G	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This STANDARD is not met as evidenced by: Based on medical record review, policy review, review of medication error reports and interview, the facility failed to ensure medications were administered without significant error. Actual harm occurred on 06/06/25 when Resident #10, who had moderately impaired cognition and was dependent of staff to prepare and administer medications, received medications prescribed for another resident that included cardiac medications that lower the heart rate and blood pressure, medication to prevent platelets from clumping together, medication to treat gout and antianxiety medications. This resulted in the resident experiencing a change in condition requiring transport to the emergency room. The resident was subsequently admitted and treated for hypotension (low blood pressure) and bradycardia (low pulse) with intravenous fluids and an overnight hospital stay for monitoring secondary to the medication error after receiving incorrect medication that was prescribed for another resident. This affected one resident (#10) of two residents reviewed for medication errors. Findings include:	F 0760	Resident #10 was sent to the ER by the physician on 6/6/25. She returned to the facility on 6/7/25 with no lasting effects of medication error. She was assessed on 6/23/25, 6/30/25 and 7/8/25 by NP since readmit with no ill effects identified. A care conference was held with the family on 6/17/25 with no concerns identified. All residents have the ability to be affected. Therefore, an initial audit was conducted by the DON or designee on 6/6/25 to ensure all residents have appropriate photo identification in the medical record. Any negative findings were addressed immediately. LPN responsible for the error was educated on medication rights to include how to identify a resident on 6/6/25 by the DON. Per policy, a discipline was also issued to the LPN responsible by the DON on 6/6/25 to prevent recurrence. Audits for medication errors were completed by RCS weekly between 6/6/25 and 6/25/25 with no identified errors. All nurses were reeducated by 7/14/25 by the DON or designee on medication pass policy and procedure to include when a nurse is unable to verify resident identification with the medical record picture, they must ask the resident their name and get a response prior to administering the medication. If the resident does not respond, they are to get assistance from other staff members. Medication pass observations of 5 nurses per week x 4 weeks will be conducted by DON or designee to ensure no significant medication errors occur. Any negative findings will be addressed immediately. The DON is responsible for ongoing compliance. Results of audits will be reviewed at QAPI for adjustments as needed.	07/14/2025

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F 0760	Continued From page 5 Review of Resident #10's medical record revealed diagnoses including muscle wasting, osteoarthritis, hypertensive heart disease with heart failure, depression, Vitamin B12 deficiency anemia, pain, hyperlipidemia, and hypothyroidism. Resident #10 had no known allergies. A quarterly Minimum Data Set (MDS) assessment dated 04/04/25 revealed Resident #10 was usually able to make herself understood, was usually able to understand others, and was moderately cognitively impaired. Review of the monthly blood pressures recorded between December 2024 and June 2025 revealed the following: 12/04/24 was 127/72 millimeters of mercury (mm Hg) (normal blood pressure is 120/80 mm Hg). 01/01/25 was 134/78 mmHg 02/01/25 was 132/80 mmHg 03/02/25 was 126/74 mmHg 04/02/25 was 122/80 mmHg 05/03/25 was 163/88 mmHg Review of monthly pulses recorded between December 2024 and June 2025 revealed the following: 12/11/24 was 70 beats per minute (bpm) with normal range 60-90 bpm) 01/01/25 was 78 bpm 02/01/25 was 76 bpm 03/02/25 was 80 bpm	F 0760		

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F 0760	Continued From page 6 04/02/25 was 76 bpm 05/03/25 was 82 bpm Review of a medication error report dated 06/06/25 revealed Resident #10 received another resident's medications in the morning. Medications listed were Allopurinol, Buspar, ferrous sulfate, isosorbide mononitrate, losartan, metoprolol succinate, Plavix and Tylenol. The physician was notified at 10:15 A.M. The type of medication error was the wrong medication given due to failure to identify the resident. A nursing note dated 06/06/25 at 11:17 A.M. indicated Resident #10 received allopurinol (used to reduce uric acid production in the body), Buspar (anti-anxiety), ferrous sulfate (iron), isosorbide mononitrate (anti-anginal), losartan (angiotensin receptor blocker used to lower blood pressure), metoprolol succinate (beta blocker that affects the heart and circulation), Plavix (anti-platelet) and Tylenol. The doctor was notified with new orders were received to monitor vital signs and mental status. Neuro checks were initiated immediately, and an order was noted to send Resident #10 to the emergency room for an evaluation. A nursing note dated 06/06/25 at 12:45 P.M. indicated Resident #10 was administered the wrong medication. The note included vital signs were stable and no signs of altered mental status were noted.	F 0760		

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F 0760	Continued From page 7 An eINTERACT Transfer Form dated 06/06/25 indicated the nurse practitioner ordered to send Resident #10 to the emergency room (ER) for an evaluation. Vital signs included temperature 97.3 degrees Fahrenheit, pulse 110 (bpm), respirations 18 and blood pressure 123/86 (mmHg). Oxygen saturation was 92% on room air (normal 92-100% on room air/without oxygen). Resident #10 was not on anticoagulants and had no known allergies. No changes were observed in mental status or functional status. The clinician was notified on 06/06/25 at 10:00 A.M. A nursing note dated 06/06/25 at 2:29 P.M. indicated Resident #10 left the facility via squad for the hospital at 12:25 P.M. A nursing note dated 06/06/25 at 2:30 P.M. indicated Resident #10 was being admitted to the hospital for overnight observation. Review of Resident #10's physician orders revealed none of the medications Resident #10 was administered in error on 06/06/25 were ordered for the resident. A hospital admission history and physical dated 06/06/25 revealed Resident #10 presented to the emergency room with hypotension (decreased blood pressure). The hospital record included, "unfortunately she was given another	F 0760		

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F 0760	Continued From page 8	F 0760		

resident's medication" including allopurinol 200 milligrams (mg), Buspar 5 mg, Plavix 75 mg, isosorbide 60 mg, losartan 100 mg, metoprolol 100 mg, and Tylenol 650 mg. Resident #10 became lethargic, bradycardic, and hypotensive so Emergency medical services (EMS) was called. Upon examination, Resident #10 was easily awakened but spoke nonsensically which was reportedly her baseline. Resident #10 was able to move her extremities and denied any pain. On 06/06/25 at 3:30 P.M., a blood pressure (BP) of 81/45 and pulse of 56 was recorded. On 06/06/25 at 3:45 P.M. a BP of 99/54 and pulse of 48 was recorded. On 06/06/25 at 4:00 P.M. a BP of 87/55 and pulse of 47 was recorded. On 06/06/25 at 4:15 P.M. a pulse of 47 was recorded. A note indicated Resident #10 had hypotension throughout her ER stay but was improving with intravenous (IV) fluids. The bradycardia (low heart rate) was likely due to administration of the beta blocker medication (in error). The plan was to admit the resident for overnight observation and continue IV fluids.

A hospital note dated 06/06/25 at 1:13 P.M. indicated Resident #10 presented via ambulance from the nursing home for complaints of hypotension and bradycardia with lethargy. Staff stated Resident #10 was "accidentally administered medication ordered for a different resident". The medications included isosorbide, losartan and

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F 0760	Continued From page 9 metoprolol. Hospital discharge records revealed admitting diagnosis of accidental medication overdose with multiple hypotensive medications. The resident presented (to the emergency room) with hypotension and bradycardia. A nursing note dated 06/07/25 at 1:09 P.M. indicated Resident #10 returned from the hospital. Resident #10 was in observation for lethargy and hypotension. Resident #10 received IV fluids for low blood pressure and pulse. On 06/25/25 at 2:50 P.M., the Administrator verified the medication error on 06/06/25 was identified before the nurse (LPN #130) administered Resident #10's medication to the other resident. The NP was notified, and Resident #10 was sent to the ER for evaluation. On 06/25/25 at 5:38 P.M., Licensed Practical Nurse (LPN) #130 verified the medication errors occurred after she failed to identify the correct resident prior to administering the medication. Review of the facility's Medication Administration and Documentation policy (revised 06/26/24) revealed medications may only be administered to the resident for whom they were prescribed. Prior to and during administration, the nurse must observe the "5 rights" of medication administration including administering the	F 0760		

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F 0760	Continued From page 10 medication to the right person. This deficiency represents non-compliance investigated under Complaint Number OH00166414.	F 0760		