STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365555	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Brien Memorial Health Care C	563 Brookfield Ave SE Masury, OH 44438

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review, review of the facility Self-Reported Incident (SRI), interview with facility staff, and review of the facility's policy on abuse, the facility failed to ensure Resident #65 and Resident #87 were free from sexual abuse. This affected three residents (Resident #27, Resident #65, and Resident #87) of three residents reviewed for sexual abuse. The facility census was 85. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnosed included but not limited to Parkinson's disease without dyskinesia, without mention of fluctuations, dementia in other diseases classified elsewhere unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety with other behavioral disturbance, major depressive disorder, and unspecified disorder of adult personality and behavior. Review of the behavior care plan, dated 02/05/24, revealed Resident #27 had behaviors to include sitting next to female residents in the lounge and holding hands. Resident #27 has been sent out to psychiatric services for inappropriate behavior. Interventions included administer medications as ordered, monitor/document for side effects and effectiveness, anticipate resident needs, assist resident to develop more appropriate methods of coping and interaction, encourage resident to express feelings appropriately, educate resident/family/caregivers on successful coping and interaction strategies, explain all procedures, if reasonable discuss resident's behavior, intervene as necessary to protect the rights and safety of others, approach in a calm manner, divert attention, remove from situation and take to alternate location as needed, minimize potential for the resident's disruptive behaviors, monitor behavior episodes and attempt to determine underlying cause, praise any indication of progress/improvement in behavior, 15 minute safety checks, room located near nurses' station, and one on one sitter. Review of the Admission Minimum Data Set (MDS) Assessment, dated 02/14/24, revealed Resident #27 had impaired cognition. No behaviors or mood was noted. Review of the following information revealed Resident #27 had two incidents of sexual abusive behavior towards Resident #65 and Resident #87: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365555	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Brien Memorial Health Care C	563 Brookfield Ave SE Masury, OH 44438

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnosis included but not limited to unspecified dementia, unspecified severity, with psychotic disturbance, with other behavioral disturbance, delirium due to known psychological condition, and hypothyroidism. Review of the Admission Minimum Data Set (MDS) Assessment, dated 03/13/24, revealed Resident #65 had severely impaired cognition. Behaviors were noted to include physical, verbal towards others and wandering. Review of Resident #65's care plan dated 03/19/24 revealed the resident had potential to be physically aggressive related to dementia. Resident #65 hits, slaps, kicks, pinches, and attempts to bite staff. Interventions include administer medications as ordered, monitor/document for side effects and effectiveness, assess and address for contributing sensory deficits, analyze time of day, places, circumstances, triggers, and what de-escalates behavior and document. Review of Resident #27's progress note dated 03/28/24 at 10:30 A.M. revealed State tested Nursing Assistant (STNA) #187 observed Resident #27 in Resident #65's room. Resident #27 was observed touching Resident #65's breasts on top of her clothes. Residents were immediately separated, and notifications were done. Both resident #27 and Resident #65 were continued on 15-minute checks. Resident #27 was moved to a different unit. Review of the facility's Self-Reported Incident (SRI) #245723 for sexual abuse, dated 03/28/24, indicated STNA #187 observed Resident #27 in Resident #65's room. Resident #27 was observed touching Resident #65's breasts on top of her clothes. Residents were immediately separated, and notifications were done. Both resident #27 and Resident #65 were continued on 15-minute checks. Resident #27 was moved to a different unit. B, Review of the medical record for Resident #87 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included but were not limited to, acute kidney failure, chronic kidney disease, stage 3B, thyrotoxicosis unspecified, type 2 diabetes mellitus (DM) with hyperglycemia, heart failure, and morbid obesity. Review of Resident #87's Admission Minimum Data Set (MDS) Assessment, dated 03/12/4, revealed Resident #87 had intact cognition with no behaviors. Review of Resident #87's progress note dated 03/29/24 at 11:23 A.M. revealed Resident #87 reported to RN #172 Resident #27 kissed her and touched her breast. Resident #87 had already separated herself from Resident #27 and came to the nurse's station. A skin assessment was completed with no abnormal findings. All notifications to physician and family were done. Resident #27 was provided one on one staff (1:1). All notifications were completed with an order to send Resident #27 out to the hospital for evaluation. Resident #27's family member agreed to transport to hospital. Resident #27's family expressed she feels his behavior is medication related. Review of Resident #27's progress note dated 03/29/24 at 12:09 P.M. revealed Physician #194 was notified of Resident #27's behavior and gave order to send to hospital due to increased behaviors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365555	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Brien Memorial Health Care C	563 Brookfield Ave SE Masury, OH 44438

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's progress note dated 03/29/24 at 1:53 P.M. revealed Resident #87 reported to Registered Nurse (RN) #172 that Resident #27 kissed her and touched her breast. Resident #87 had already separated herself from Resident #27 and came to the nurse's station. Resident #27 was provided one on one staff (1:1). All notifications were completed. Order to send Resident #27 out to the hospital for evaluation. Resident #27's family member agreed to transport to hospital. Resident #27's family expressed she feels his behavior is medication related. Review of the facility's Self-Reported Incident (SRI) #245753 for sexual abuse, dated 03/29/24, indicated Resident #87 reported to RN #172 Resident #27 kissed her and touched her breast. Resident #87 had already separated herself from Resident #27 and came to the nurse's station. A skin assessment was completed with no abnormal findings. All notifications to physician and family were done. Resident #27 was provided one on one staff (1:1). All notifications were completed. Order to send Resident #27 out to the hospital for evaluation. Resident #27's family member agreed to transport to hospital. Resident #27's family expressed she feels his behavior is medication related. Interview on 04/09/24 at 2:02 P.M. with Regional Administrator (RA) #193 revealed she found out about both SRI's on 03/28/24 and on 03/29/24 regarding sexual abuse. RA #193 reported on 03/28/24 STNA #187 observed Resident #27 on the locked dementia unit in Resident #65's room fondling her breast. RA #193 reported they were immediately separated and assessed. RA #103 reported Resident #27 was moved off the unit to another unit to be closer to the nurse's desk and on 15-minute checks. RA #193 reported all notifications were done. RA #193 reported on 03/29/24 Resident #27 had kissed and touched the breast of Resident #87. RA #193 reported Resident #87, who is alert and oriented reported the incident to RN #172. RA #193 reported all assessments and notifications were done. RA #193 reported physician ordered Resident #27 to be sent out to hospital for evaluation regarding his behaviors. Resident #27 was put on one on one (1:1) until transferred out to the psychiatric hospital. RA #193 reported Resident #27 was not to return to facility, however on 04/04/24 Resident #27 was sent back to facility. RA #193 reported Resident #27's daughter told the psychiatric hospital to take Resident #27 off all his psychiatric medications. Upon return Resident #27 was on 15 minute checks. RA #193 reported Resident #27 was seen by psychiatric physician and psychiatric nurse practitioner (NP) who put him back on psychiatric medications. Observation on 04/10/24 at 7:35 A.M. revealed STNA #122 sitting outside of Resident #27's room. The door was closed to his room. Interview with STNA #122 reported Resident #27 was started on 1:1 due to his sexual inappropriate behavior. Interview on 04/10/24 at 9:13 A.M. with RA #193 revealed Resident #27 was put on 1:1 with sitter last night. RA #193 reported since Resident #27 returned, medication on board, and sitter 1:1 he hasn't had any more incidents. RA #193 reported the sexual behaviors were new to him. Interview on 04/11/24 at 7:58 A.M. with RN #172 revealed she heard Resident #27 touching Resident #65 inappropriately on the dementia locked unit. She reported the residents were separated and Resident #27 was moved off the unit to another unit to be closer to the nurses' station. Both residents were on 15-minute checks. RN #172 reported she was working the day Resident #87 reported Resident #27 had kissed her and touched her breast. RN #87 reported Resident was already separated from Resident #27. RN #172 reported Resident #27 was sent to hospital for evaluation of behaviors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365555	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Brien Memorial Health Care C	563 Brookfield Ave SE Masury, OH 44438

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/11/24 at 9:25 A.M. with Psychiatric Physician (PP) #194 revealed the sexual behaviors of Resident #27 were new behaviors. PP #194 reported he was notified of the incidents on 03/28/24 and 03/29/24. PP #194 reported the facility had done everything they could to monitor Resident #27's sexual behaviors. PP #104 reported the facility is willing to take the challenging residents that no one else will take, so it only makes sense there will be challenging incidents. Interview on 4/11/24 at 10;39 A.M. with LPN # 100 revealed on 03/28/24 he worked and was notified by STNA #187 regarding Resident #27 touching breast of Resident #65. LPN #100 reported the residents were immediately separated and once he was notified, he did assessments on both resident and notified physician and family. LPN #100 reported Resident #27 was moved off the unit and physician ordered a psychiatric consult. Both Residents on 15-minute checks. Interview on 04/11/24 at 11:41 A.M. with STNA #187 revealed on 03/28/24 she observed Resident #27 in Resident #65's room grabbing and squeezing her breast over top of her clothes. STNA #187 immediately separated them and notified LPN #100. STNA #187 reported LPN #100 immediately assessed both residents and notified physician and family. STNA #187 reported Resident #27 was moved to another unit. STNA #187 reported both residents were on 15-minute checks. Interview on 04/18/24 at 10:58 A.M. with Psychiatric Nurse Practitioner (PNP) #209 revealed she was notified of the two incidents regarding sexual inappropriate touching by Resident #27. PNP #209 reported she saw Resident #27 on 03/26/24 for the first time had she didn't have any sexual behavior concerns. PNP #209 reported he was confused and thought he was in the hospital. PNP #209 reported she made some adjustments to his medications at that time. PNP #209 reported the facility did everything possible to prevent this from happening. PNP #209 reported the facility takes challenging behaviors and you would expect behaviors like this. PNP #209 reported the facility is quite phenomenal monitoring the behaviors. Review of facility policy titled, Resident Abuse Prevention Practices, dated 10/2022, revealed all residents would be protected from verbal, mental, emotional, or financial abuse by staff, families, residents, visitors or outside ancillary service employees or in any situation that would be harmful to the resident. The facility's policy defines sexual abuse as Non-consensual sexual contact of any type with a resident. Includes but is not limited to sexual harassment, sexual coercion, or physical sexual assault. Sexual contact in non-consensual if either the resident appears to want the contact to occur but lacks the cognitive ability to consent or does not want the contact to occur. This deficiency represents non-compliance investigated under Complaint Number OH00152730, Complaint Number OH00152066, and is an example of continued non-compliance from the survey dated 02/29/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365555	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Brien Memorial Health Care C	563 Brookfield Ave SE Masury, OH 44438

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on interviews and record reviews the facility failed to ensure residents were free from significant medication errors. This affected two residents (#47 and #86) out of six residents observed and reviewed for medications. The facility census was 85. Findings included: 1. Review of medical record revealed Resident #47 was admitted to the facility on [DATE]. Diagnosis included but not limited to surgical aftercare following surgery on the circulatory system, sick sinus syndrome, presence of cardiac pacemaker, COVID-19, bradycardia, tachycardia, tachypnea, and hypertensive crisis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had intact cognition. Review of the investigation report revealed on 03/02/24 at 8:20 A.M. Licensed Practical Nurse (LPN) #211 administered to Resident #47 the following fourteen medications in error as follows: Colace 1 capsule (for constipation), Lactulose Solution 10 gram (GM)/15 milliner (ML) give 30 ml (for constipation), Glycolax powder 17 gm (for constipation), Ergocalciferol capsule 1.25 milligram (MG) 1 capsule (supplement), Duloxetine Hydrochloride (HCl) Delayed Release (DR) particles 60 mg (antidepressant), Loratadine 10 mg (for allergies), Ropinirole HCl 2 mg 1 tablet (for restless legs syndrome), Trelegy Ellipta inhalation aerosol powder breath activated 100-62.5-25 1 puff inhalation (for chronic obstructive pulmonary disease), Divalproex Sodium oral delayed release 250 mg 2 tablets (mood stabilizer), Namenda 5 mg 1 tablet (for cognitive decline), Apixaban 5 mg (anticoagulant), Metformin 500 mg 1 tablet (for diabetes mellitus), Metoprolol Succinate extended release (ER) 24 hours 50 mg 1 tablet (for hypertension), and Furosemide 40 mg (diuretic). LPN #211 and LPN #212 were suspended pending investigation and LPN #211 was terminated due to the medication errors and LPN #212 turned in her resignation. Interview on 04/15/24 at 12:11 P.M. with Regional Administrator (RA) #193 revealed she was notified of the wrong medications given to Resident #47. RA #193 reported the physician was notified and ordered to monitor the resident at the facility. RA #193 reported Resident #47's family was notified. RA #193 reported later the day Resident #47 had an emesis and not feeling well and was sent to the hospital for evaluation and returned the same day with no negative outcomes. Interview on 04/15/24 at 12:17 P.M. with Resident #47's family revealed she was notified immediately of the wrong medications given. Resident #47's family reported she had no negative consequences from the wrong medications given. Resident 47's family reported she had emesis and not feeling right and sent to hospital for evaluation and returned the same day with no new orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365555	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Brien Memorial Health Care C	563 Brookfield Ave SE Masury, OH 44438

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/16/24 at 9:30 A.M. with Physician # 197 revealed he was notified of the medications given in error to Resident #47 on 03/02/24. Physician #197 reported he doesn't believe the wrong medications caused any negative effect. Physician #197 reported he initially had the staff monitor Resident #47 at the facility. Physician #197 reported Resident #47 had some emesis and was sent to hospital for evaluation and returned same day. Physician #197 reported Resident #47 had similar symptoms prior to this incident and multiple hospital visits for those symptoms. Interview on 04/17/24 at 9:10 A.M. with Administrator reported she was notified immediately on 03/02/24 by LPN #211 of the wrong medications given to Resident #47. The administrator reported she lives seven minutes from the facility and came to the facility immediately to start the investigation and ensure proper protocols were followed. The administrator reported LPN #211 did not do follow the five rights of medications and took the word of LPN #212 who the resident was. Review of facility policy, Medication Administration, revised 07/2023, revealed to identify the resident and medications are to be given within one hour prior to or after time ordered. 2. Review of the medical record revealed Resident #86 was admitted to the facility on [DATE] and discharged on [DATE] to home. Diagnosis included but not limited to cerebral infarction, traumatic subdural hemorrhage with loss of consciousness, COVID-19, atrial fibrillation, dysphagia, type 2 diabetes mellitus (DM) without complications, depression, displaced comminuted fracture of shaft of right femur, displaced trimalleolar fracture of left lower leg, injury unspecified, unspecified fracture of unspecified lumbar vertebra, multiple fractures of ribs, unspecified, minor contusion of unspecified kidney, sternal manubrial dissociation, and subsequent encounter for fracture with routine healing, contusion of heart. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #86 had intact cognition. Review of Resident #86's physician orders and Medication Administration Records (MARS) for January 2024 revealed the following medications were not administered the day of admission per physician orders: Gabapentin 600 mg 1 tablet three times a day (TID) (for pain) was ordered to start 01/12/24 at bedtime, but was first administered 01/13/24 at bedtime. Methocarbamol 1000 mg 1 tablet four times a day (QID) (for spasms and pain) was ordered to start 01/12/24 at evening, but was first administered on 01/15/24 at bedtime, Sennosides-Docusate Sodium 8.8-50 mg give 2 tablets bid, (for constipation) was ordered to start 01/12/24 in the evening but was first administered on 01/13/24 in the evening. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365555	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Brien Memorial Health Care C	563 Brookfield Ave SE Masury, OH 44438

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #86's physician orders and MARS for January 2024 revealed the following medications were ordered for administration the morning of 01/13/24 and were not administered as ordered: Potassium Chloride extended release (ER) 10 milliequivalent (MEQ) one tablet qd (for low blood potassium) was ordered for administration on 01/13/24 in the morning but was administered 01/13/24 in the evening, Aspirin 325 mg 1 tablet bid should have been administered 01/13/24 in the morning but was administered on 01/13/24 in the evening, Bisacodyl EC (enteric coated) DR (delayed release) 5 mg 1 tablet bid (for constipation) should have been administered 01/13/24 in the morning but was administered 01/13/24 in the afternoon, Calcium Citrate tablet 950 mg give 3 tablets bid (for low calcium levels) should have been administered on 01/13/24 in the morning but was administered 01/13/24 in the afternoon, Glycolax Powder give 17 gram bid (for constipation), should have administered 01/13/24 in the morning but was administered 01/13/24 in the afternoon. Resident #86 was ordered to receive Metoprolol Tartrate 75 mg 1 tablet bid (for hypertension) starting 01/13/24 in the morning but it was first administered 01/15/24. Review of Resident #86's physician orders and MARS for January 2024 revealed the following medications were ordered for administration on 01/13/24 but were not administered as ordered until 01/14/24: Amlodipine Besylate 5 mg 1 tablet (for hypertension), Aspercreme Lidocaine external patch 4% (for pain) apply to skin topically one time a day (QD), Atorvastatin Calcium 40 mg 1 tabled qd (for cardiovascular disease), Docusate Sodium (for constipation) 50 mg capsule give two, Duloxetine HCl delayed release (DR) particles 30 mg 1 capsule in the afternoon (for depression), Farxiga 5 mg 1 tabled qd (for chronic kidney disease), Folic Acid 1 tablet qd (vitamin for anemia), Levothyroxine Sodium 125 micrograms (mcg) (for hypothyroidism), Lisinopril 20 mg 1 tabled qd (to treat high blood pressure/heart failure), Pantoprazole Sodium DR 40 mg qd (gastrointestinal medication). Further review of Resident #86's physician orders and MARS for January 2024 revealed the resident should have received Trulicity 4.5 mg/0.5 ml inject 4.5 mg subcutaneous (SQ) every Friday (to treat type 2 diabetes mellitus) on 01/19/24 but it was administered 01/26/24. Interview on 04/16/24 at 12:52 P.M. with RA #193 verified Resident #86's medications were not faxed to the pharmacy on 01/12/24 when the resident was admitted . RA #193 verified Resident #86 did start not receiving any of her medications until 01/13/24, the day following admission. Interview on 04/17/24 at 11:06 A.M. with RA #193 verified LPN #213 did not put orders in the chart or faxed to pharmacy on 01/12/24 during admission. Interview on 04/17/24 at 11:27 A.M. with LPN #109 (who is no longer employed at facility) revealed she worked on 01/13/24 and Resident #86's family informed her the resident didn't receive any medications last night. LPN #109 reported she immediately faxed over medications to pharmacy. LPN #109 verified Resident #86 did not receive any medications on 01/12/24. Interview on 04/17/24 at 11:30 A.M. with LPN #213 via phone revealed she worked 01/12/24 dayshift (6:30 A.M. through 7:00 P.M.). LPN #213 reported she doesn't remember a lot because she is no longer employed at the facility. LPN #213 reported she did everything required for admission assessment and faxed medications to pharmacy. LPN #213 then reported the admission nurse should have faxed medications to pharmacy than changed the report to the midnight nurse should have faxed medications to pharmacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365555	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Brien Memorial Health Care C	563 Brookfield Ave SE Masury, OH 44438

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/24 at 12:46 P.M. with Quality Assurance (QA) Corporate Nurse #195 verified Resident #86 did not receive her medications as ordered by the physician. Interview on 04/17/24 at 2:15 P.M. via phone with Previous Director of Nursing (DON) #214 revealed she worked as a floor nurse on 01/13/24. DON #214 reported the facility had a lot of admissions and she doesn't really remember this one. DON #214 reported the admission medications should have been done by the admitting nurse and faxed to the pharmacy. DON #214 reported if they weren't done and that was passed along in report she would have done it. Review of facility policy, Medication Administration, revised 07/2023, revealed to identify the resident and medications are to be given within one hour prior to or after time ordered. This deficiency represents non-compliance investigated under Complaint Number OH00152066 and Complaint Number OH00152042.