

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER O'Brien Memorial Health Care C		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49774</p> <p>Based on observation, interview, and policy review the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to effect 75 of the 77 residents who ate food prepared in the kitchen. Residents #13 and #18 did not take any nourishment by mouth.</p> <p>Findings include:</p> <p>Observations on 08/07/24 at 8:14 A.M., during a tour of the kitchen with the administrator, revealed multiple concerns with kitchen cleanliness. Of the two hand washing stations, both were unclean and there were water stains and soap scum on the sink and back splash and grime around the faucets and handles. The hand washing station located next to the rear exit door did not have paper towels. The [NAME] shelf located beneath a workstation near the entrance to the kitchen had dried food debris on the bottom shelf and employee personal items including keys and a beverage cup with a lid and straw were sitting on top of the workstation. The bottom shelf of the workstation located next to the two-compartment sink where baking pans and other food prep items were stored had a large amount of dried food debris underneath the baking pans. Observation of the walk-in cooler revealed dark black spots covering the two large, grated shelving units, walls, and ceiling which came off when a finger ran over the areas. The fan inside the cooler was covered in black dust. The floor and the seam where the floor and wall met the cooler had dried food and other unidentified caked on debris.</p> <p>Interview on 08/07/24 at 11:40 A.M. with Regional Administrator #200 confirmed the walk-in cooler contained what looked like mold and any food that was not in a sealed box was discarded.</p> <p>Review of the State of Ohio Food Inspection Report dated 07/30/24 revealed cleanliness of equipment and food contact surfaces and utensils were a repeat violation. The report also revealed no paper towels were observed at the handwashing sink during the inspection.</p> <p>Review of the Kitchen Floor Cleaning and Maintenance Policy dated March 2023 revealed staff were to deep clean the kitchen floor every four to six weeks.</p> <p>Review of the Walk-in Freezer and Walk-in Cooler Policy dated 10/17/23 revealed the walk-in cooler was to be cleaned, swept, and mopped once weekly.</p> <p>Interview with the Assistant Director of Nursing on 08/07/24 at 2:30 P.M. revealed Residents #13 and #18 received nothing by mouth.</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00155377.</p>		