

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  05/22/2025
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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810</b></p> <p>Based on closed medical record review, review of the acute care hospital paperwork, facility policy review and interview, the facility failed to provide care per physician's orders and failed to timely identify and address a change in condition for Resident #71 resulting in hospitalization .</p> <p>Actual Harm occurred on 03/16/25 when Resident #71 began displaying changes in his baseline mentation, eating patterns, and activity level and staff failed to document, notify the physician and/or timely address the change in condition resulting in Resident #71 continuing to decline without physician notification through 03/22/25 when Resident #71 was transferred to an acute care hospital at the insistence of his family and was diagnosed with sepsis related to aspiration pneumonia, fecal impaction, acute metabolic encephalopathy, and urinary tract infection.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #71 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #71 had diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and hypertension.</p> <p>Review of the care plan dated 02/12/25 revealed Resident #71 had a nutritional problem. Interventions included providing diet as ordered and monitoring intake and weight as ordered. Resident #71 also had a care plan focus identifying he was incontinent of bowel and bladder. Interventions included for staff to provide check and changes every two hours and as needed.</p> <p>Review of a physician's order dated 02/13/25 revealed an order to clean Resident #71's right elbow with normal saline, apply non adherent dressing, and a dry dressing daily. Review of the treatment administration record (TAR) dated February 2025 revealed that the wound care was not provided as ordered on 02/13/25, 02/14/25, 02/18/25, 02/19/25, 02/22/25, or 02/27/25.</p> <p>Review of a physician's order dated 02/13/25 revealed an order to weigh Resident #71 on admission and then every week for four weeks. The order was set to expire on 03/24/25. Resident #71 weighed 119 pounds on admission (02/12/25) and at his last weight on 03/10/25 was 110 pounds which was a 7.5% weight loss in less than 30 days, indicating a severe weight loss for the resident. Resident #71 was identified as a weight loss on 03/11/25 and was ordered a dietary supplement twice daily. No further weights were documented. There was no documented evidence the physician was notified of the severe weight loss.</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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had severe cognitive impairment with a memory problem. The assessment revealed Resident #71 required staff supervision to moderate assistance for all activities of daily living. Resident #71 was frequently incontinent of urine and bowel.</p> <p>Review of the nursing documentation from 03/16/25 to 03/22/25, until the note on 03/22/25 at 12:53 A.M., revealed no documentation, physician notification and/or interventions regarding any changes in Resident #71's baseline mentation, eating patterns, or activity level.</p> <p>Review of the bowel documentation revealed Resident #71 had small to medium bowel movements on 03/16/25, 03/18/25, 03/19/25, and one small clay-like bowel movement on 03/21/25.</p> <p>Review of skilled nursing documentation dated 03/22/25 at 12:53 A.M. revealed the resident's blood pressure was 114/50, heart rate 81, respirations 18, his pulse oximetry was 94% on room air, and his temperature was 97.9 degrees Fahrenheit.</p> <p>Review of the nursing progress note dated 03/22/25 at 5:41 P.M. revealed Resident #71 was not eating or drinking much since he was sick a week prior and his family was concerned. The doctor was notified, and an order was obtained to transfer the resident to the hospital.</p> <p>Review of the medical record revealed Resident #71 did not return from the hospital.</p> <p>Review of the medical record for Resident #71's stay at the acute hospital revealed he was admitted [DATE] with sepsis protocol. The resident was assessed to have a fecal impaction that nurses were able to manually remove with good results. The resident was assessed to have a urinary tract infection which the emergency room placed in an indwelling urinary catheter with good results, and he required intravenous antibiotics. Resident #71 was also assessed to have bilateral lower lung infiltrates suspected of pneumonia. Hospital diagnoses included sepsis related to aspiration pneumonia, fecal impaction, acute metabolic encephalopathy, and urinary tract infection.</p> <p>Interview on 05/20/25 at 11:14 A.M. with Clinical Director #501 confirmed Resident #71 was ordered weekly weights but did not receive one the week of 03/17/25. She also confirmed that no wound care was documented as completed for his right elbow on 02/13/25, 02/14/25, 02/18/25, 02/19/25, 02/22/25, and 02/27/25. Clinical Director #501 also confirmed staff failed to document the resident's identified decline in eating and drinking for a week based on the 03/22/25 nurse's note. In addition, there was no evidence the physician, family or dietician were notified of this change.</p> <p>Telephone interview on 05/20/25 at 1:27 P.M. with Resident #71's daughter reported the resident weighed 107 pounds on 03/22/25, when he went to the hospital. The resident had a raging bladder infection, and his urethra was swollen shut. She also reported that when the resident was admitted to the hospital, they found a fecal impaction and aspiration pneumonia. Resident #71's daughter reported that after going to visit him on 03/22/25, they had had enough, her father was not his normal pleasant self, so the family insisted he be sent to the hospital. The resident's daughter revealed she was glad they insisted on the transfer and indicated the resident would not be returning to the facility due to the concerns they had. Resident #71's daughter reported that her father had been pleasantly confused and loved to be up and about in the facility in his wheelchair but about a week prior to him being transferred to the hospital, he had been refusing to get up and was going to bed earlier than usual.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 05/21/25 at 8:14 A.M. with Licensed Practical Nurse (LPN) Admissions Director #509 revealed she was told Resident #71 would not be returning to the facility following the hospitalization because the family was not happy with his care.</p> <p>Interview on 05/21/25 at 9:40 A.M. with Regional Clinical Supervisor #511 revealed she was aware (through a review of Resident #71's medical record) the facility had not provided care to Resident #71 to timely identify a change in his condition.</p> <p>Review of the facility policy change of condition, resided February 2024, revealed it was the policy of this facility to inform the resident, consult with the resident's physician/health care practitioner, and the resident's representative when there was an accident involving the resident which results in injury and may require physician/medical intervention, a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment significantly or a decision is made to transfer or discharge the resident. Nurses were to document what, where, symptoms, assessments, physician's orders, treatments, and notifications of any change in condition.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00164712.</p>		