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	06/13/2024

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** 43063 Based on observation, interviews, record review, review of facility self-reported incidents (SRIs), and facility policy review the facility failed to ensure physician's orders were followed to prevent potential resident-to-resident abuse. This affected three residents (#7, #21, and #37) of 18 residents reviewed for abuse. This had the potential to affect three other residents (#18, #19, and #67) on the 400-Unit. The facility census was 81. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including schizoaffective disorder bipolar type, mild cognitive impairment, and anxiety. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 was able to understand staff and was able to be understood. She refused to answer questions on the cognitive assessment; however, staff stated she had impaired memory. Resident #37 knew she was in a nursing home, where her room was, staff names and faces, and the season. Staff stated Resident #37 was independent regarding decision making for tasks of daily life. Review of the facility SRIs tracking number 247416 dated 05/12/24 revealed at 1:20 P.M. Resident #37 went into Resident #21's room and slapped her in the face. No injuries were noted, and Resident #37 was placed on 15-minute-checks. Additionally, a door alarm was placed to notify staff of wandering. Review of the facility SRIs tracking number 247423 dated 05/12/24 revealed at 18:15 P.M. a state tested nurse aide (STNA) had just left a resident's room after providing care and observed Resident #37 stand, approach Resident #7 and slap her once on both sides of the face. The STNA immediately responded and placed Resident #37 on a couch in the lounge area. Resident #7 was taken to her room. Both residents were assessed, and no injuries were noted. Resident #37 was provided one-on-one supervision until transported to the hospital for evaluation for escalating behaviors. While at the hospital, Resident #37's labs and urinalysis were withing normal limits. When she returned to the facility, she continued on one-on-one observations at all times to monitor behaviors. Review of the monthly physician's orders for June 2024 revealed Resident #37 had an order dated 05/13/24 for constant one-on-one supervision for prevention and safety. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication administration record (MAR) and treatment administration record (TAR) for June 2024 for Resident #37 revealed staff were documenting she was to have one-on-one supervision. Review of the nursing progress note dated 06/09/24 at 10:20 A.M. revealed Resident #37 had behaviors with attempting to touch and sit on other residents. Staff had separated her from other residents, and the physician was updated. A new order was obtained to send the resident to the emergency room to be evaluated. The nursing progress note on 6/10/24 at 1:49 A.M. stated Resident #37 was back at the facility and an intervention of one-on-one supervision was initiated as well as 15-minute safety checks. Observation with Registered Nurse (RN) #1275 on 06/11/24 at 9:26 A.M. revealed Resident #37 to be in her room, awake and lying in her bed. There were no staff in her room or in the hallway on the unit. RN #1275 verified Resident #37 was to have someone with her at all times. RN #1275 was only able to find one staff member, State tested Nurse Aide (STNA) #1223 who was in the lounge/common area out of view from Resident #37's room. STNA #1223 came to Resident #37's room and stated she was the only staff member on the unit to care for six residents. STNA #1276 went on break which left only her on the unit. On 06/11/24 at 9:30 A.M., STNA #1276 returned to the unit and stated she had been on her 15-minute break. She stated she left the floor at 9:20 A.M. and was unaware that she was supposed to update staff on other units that she would need someone to replace her so that STNA #1223 could continue to perform one-on-one supervision to Resident #37. Interview on 06/11/24 at 9:47 A.M. with the Director of Nursing (DON) verified Resident #37 had an order for one-on-one supervision due to escalated behaviors on 06/09/24. She stated staff should stay with the resident and call staff on other units when they needed a break so they could replace her on the floor. Review of the facility policy titled, Resident Abuse Prevention Practices, revised October 2022, revealed it was the policy of the facility to protect all residents from abuse. This deficiency represents non-compliance investigated under Complaint Number OH00154456.

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45441 Based on record review and interview, the facility failed to ensure all employees had reference checks prior to hire. This affected seven of sixteen employees reviewed for abuse. This had the potential to affect all 81 residents residing in the facility. Findings include: Review of the employee file for [NAME] #1262 revealed a hire date of 01/12/22. There was no documented evidence reference checks were completed upon hire. Review of the employee file for State tested Nurse Aide (STNA) #1249 revealed a hire date of 01/31/23. There was no documented evidence reference checks were completed upon hire. Review of the employee file for Licensed Practical Nurse (LPN) #1229 revealed a hire date of 05/14/23. There was no documented evidence reference checks were completed upon hire. Review of the employee file for STNA #1217 revealed a hire date of 10/17/23. There was no documented evidence reference checks were completed upon hire. Review of the employee file for LPN #1257 revealed a hire date of 03/26/24. There was no documented evidence reference checks were completed upon hire. Review of the employee file for Housekeeper #1256 revealed a hire date of 03/26/24. There was no documented evidence reference checks were completed upon hire. Review of the employee file for Dietary Supervisor #1243 revealed a hire date of 04/10/24. There was no documented evidence reference checks were completed upon hire. Interview on 06/12/24 at 10:38 A.M. with the Administrator confirmed there was no documented evidence reference checks were completed for the above employees. This deficiency represents non-compliance investigated under Complaint Number OH00154456.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on observation, interview, record review, and facility policy review the facility failed to maintain a functioning alarm for Resident #38 as ordered by the physician. This affected one resident (#38) out of four residents reviewed for alarms. The facility census was 81. Findings include: Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnosis of dementia. Review of the physician's order dated 03/20/24 revealed Resident #38 had an order for a door alarm to the bathroom door that exited into room [ROOM NUMBER] to alert staff if he attempted to enter room [ROOM NUMBER]. Every shift was to check the function of this alarm. Review of the medication administration record (MAR) and treatment administration record (TAR) for March 2024 through June 2024 revealed staff had not documented they had ensured the alarm was functioning on afternoons on 03/23/24, 03/24/24, 03/26/24, 03/29/24, 04/18/24, 04/20/24, 04/24/24, 05/23/24, 05/28/24, and on nights on 03/22/24 and 04/23/24. Observation and interview on 06/06/24 at 10:22 A.M. with Resident #38 revealed there was an alarm on the bathroom door because women were in the adjacent room. He stated the alarm helped so he did not get confused going out the wrong bathroom door. Observation revealed the alarm was not on and functioning when the door was opened and entering the adjacent room out of the bathroom. Observation and interview on 06/10/24 at 10:29 A.M. with Licensed Practical Nurse (LPN) #1216 revealed Resident #38's bathroom door alarm, which lead to the adjacent room (female resident room), did not have a functioning alarm. LPN #1216 turned on the alarm and stated staff would turn the alarm off and forget to turn it back on. Review of the facility policy titled, Alarms: Bed, Chair, Door, Floor Alarms, Motion Detection, revised February 2024, revealed staff would check that alarms were functioning properly when assisting residents with care. Residents were not to be left unattended when alarms were removed or shut off. This deficiency represents non-compliance investigated under Complaint Number OH00154456.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 45441 Based on employee personnel file review and interview, the facility failed to ensure State tested Nurse Aide (STNA) evaluations were completed within 90 days of hire and annually. This affected six STNA's of six reviewed for performance. This had the potential to affect all 81 residents residing in the facility. Findings include: Review of the employee file for STNA #1219 revealed a hire date of 06/14/21. There was no documented evidence of an annual evaluation. Review of the employee file for STNA #1212 revealed a hire date of 01/24/21. There was no documented evidence of an annual evaluation. Review of the employee file for STNA #1200 revealed a hire date of 11/19/21. There was no documented evidence of an annual evaluation. Review of the employee file for STNA #1249 revealed a hire date of 01/31/23. There was no documented evidence of an annual evaluation. Review of the employee file for STNA #1233 revealed a hire date of 04/21/23. There was no documented evidence of an annual evaluation. Review of the employee file for STNA #1217 revealed a hire date of 10/17/23. There was no documented evidence a 90-day evaluation was completed. Interview on 06/12/24 at 10:38 A.M. with the Administrator confirmed there was no evidence 90-day evaluation for STNA #1217or annual evaluations for STNAs #1219, #1212, #1200, #1249, and #1233.

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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** 43063 Based on record review, interviews, and facility policy review the facility failed to ensure Resident #2 was free of significant medication errors. This affected one resident (#2) of 33 residents reviewed during the annual survey. The facility census was 81. Findings include: Review of medical record for Resident #2 revealed an admitted [DATE] with diagnosis including leukemia (blood cancer that affects the production and function of blood cells) not having achieved remission. Review of the discharge instructions from the hospital on 01/25/24 revealed Resident #2 was ordered Bosutinib (medication used to treat types of blood cancers such as leukemia) 500 milligrams (mg) one tablet a day for leukemia and Nilotinib HCl (medication used to treat leukemia) 200 mg one capsule two times a day related to leukemia. Both of these medications were considered oral chemotherapy drugs. Review of the care plan dated 01/26/24 for Resident #2 revealed she had leukemia and was on an oral chemotherapy drug. Interventions included administering medications as ordered. Review of the monthly physician's orders for January 2024 through April 2024 for Resident #2 revealed she had an order for Bosutinib 500 mg one tablet a day for leukemia dated 01/25/24. This medication was discontinued on 02/05/24. Resident #2 also had an order for Nilotinib HCl 200 mg one capsule two times a day for leukemia dated 01/25/24. Review of the Medication Administration Record (MAR) for January 2024 through April 2024 for Resident #2 revealed the following: Bosutinib 500 mg was not given on 01/26/24, 01/27/24, 01/28/24, 01/29/24, 01/30/24 and 01/31/24 due to the medication not being available. Nioltinib 200 mg was not given in the morning on 01/26/24, 01/27/24, 01/28/24, 02/26/24, 02/27/24, 02/28/24, 02/29/24, 03/29/24, 03/30/24, 04/01/24, 04/02/24, 04/03/24, 04/06/24, 04/07/24, 04/08/24, 04/09/24, 04/10/24, 04/11/24, 04/12/24, 04/13/24, 04/16/24, 04/17/24, 04/18/24, 04/19/24, 04/21/24, 04/22/24, 04/23/24, 04/24/24, 04/25/24, 04/26/24, and at night on 01/26/24, 01/27/24, 02/26/24, 02/27/24, 02/28/24, 03/28/24, 03/29/24, 04/01/24, 04/02/24, 04/03/24, 04/04/24, 04/05/24, 04/06/24, 04/07/24, 04/08/24, 04/09/24, 04/10/24, 04/11/24, 04/12/24, 04/14/24, 04/15/24, 04/17/24, 04/18/24, 04/20/24, 04/21/24, 04/22/24, 04/23/24 and 04/24/24, due to the medication being on order, not available, or awaiting delivery from the pharmacy. Review of the nursing progress notes dated 01/26/24 through 04/24/24 revealed Resident #2's oncologist was not notified of the oral chemotherapy medications being unavailable. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/12/24 at 10:25 A.M. with Pharmacist #1297 verified the pharmacy had not sent Resident #2's oral chemotherapy medication to the facility until 04/24/24. She stated prior to that time, the pharmacy was unable to provide this medication due to insurance not covering the medication and cost. Interview on 06/12/24 at 10:32 A.M. with Registered Nurse (RN) #1232 revealed she was aware there was an issue with getting Resident #2's oral chemotherapy medications as the insurance would not cover it, so the pharmacy would not send the medication. She stated Resident #2's oncologist was aware and stated to hold the medication until the facility received it. She did verify before the facility admitted someone, the admissions office reviewed the resident's medications to ensure they could provide the care and services to the resident. She was unable to state why the medications were not available on admission if the facility had followed this process. RN #1232 stated she was also not aware Resident #2 had any further appointments with her oncologist, Physician #1296. Interview on 06/12/24 at 11:10 A.M. with Physician #1296 revealed he saw Resident #2 on 06/12/24 in his office. He stated her previous appointment was on 02/28/24. Physician #1296 stated he only provided prescriptions for oral chemotherapy medications monthly and needed to see the resident in the office every month to assess her. At the office visit he would provide the prescription for the oral chemotherapy medication. He verified the facility had not called his office after 02/28/24 to update him that Resident #2 was not taking her medications due to unavailability. He was unable to confirm or deny if this delay in medication hindered her treatment course. Review of the facility policy titled, Medication Administration, revised May 2024, revealed nursing staff were to review the electronic medication administration record for medication administration orders and instructions and to provide the medication within one hour prior to or after the time ordered. There was nothing in the facility procedure to advise nursing staff on what to do if the medication was unavailable except that a pharmacy policy and procedure manual was available for additional guidance. This deficiency represents non-compliance investigated under Complaint Number OH00154456.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on observation, interview, record review, and facility policy review the facility failed to ensure medications were disposed of when they had expired. This affected 12 residents (#15, #32, #53, #72, #78, #177, #178, #180, #226, #227, #228, and #276) who had received expired tuberculin tests (medication to test for tuberculosis) with the potential to affect all residents in the facility. The facility census was 81. Findings include: Observation on [DATE] at 7:44 A.M. of the medication storage room located on the 600-hall with Registered Nurse (RN) #1293 revealed a bottle of Tuberculin, Purified Protein Derivative, Diluted Aplisol five milliliters (mL) that contained 50 tests, lot #68154. The date opened on the bottle stated [DATE]. Interview with RN #1293 at the time of the observation verified the medication was expired, and she discarded the medication. Review of the list provided by the facility of residents that were given tuberculosis (TB) tests for lot #68154 after the medication had expired on [DATE] included Residents #15, #32, #53, #72, #78, #177, #178, #180, #226, #227, #228, and #276. Review of the facility policy titled, Medication Administration, revised [DATE], revealed the facility should follow manufacturer instructions for expiration dates of medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on observation, interview, and facility policy review the facility failed to ensure foods were stored in a manner to prevent contamination and foodborne illness. This had the potential to affect all residents who received food from the kitchen. The facility identified two residents (#27 and #36) who received no food by mouth. The facility census was 81. Findings include: Observation on [DATE] at 8:04 A.M. of the kitchen revealed the following items open and undated in the dry storage area: one bag of potatoes, one bag of cornflakes, one bag of Cheerios, one box of pancake batter, three bags of pasta, and one jar of syrup. There were also three bags of hoagie buns that expired on [DATE]. The cooler contained the following open and undated items: nine packs of strawberries, two bags of lettuce, one container of salad mix, one tomato, half of an onion, one bag of cucumbers, and 13 prepared cups of juice. The refrigerator contained the following items open and undated: three hard boiled eggs, two boxes of chicken breasts, three packs of lunch meat, two bags of shredded cheese, one-half full container identified by [NAME] #1262 as chicken noodle soup, one bag of cooked bratwurst, and one-half full container of applesauce as identified by [NAME] #1262. There was also one bucket of pickles open and undated on the floor and one three-fourths full gallon of milk with no cap. The freezer contained the following open and undated items: one box of mixed vegetables, one bag of sausage links, one bag of green beans, one bag of chicken tenders, and one frozen pizza. There was also one box of French fries, one box of chicken filets, one box of frozen pizza, and one box of beef stew directly on the freezer floor. Interview at the time of the above observation with [NAME] #1262 confirmed food should be labeled with both an open and use by date, and no boxes should be stored on the floor. He also confirmed the expired hoagie buns and other items identified during the tour as open and undated. Review of the facility policy titled Covering, Labeling and Dating Food, dated [DATE], revealed all food stored would be covered, labeled, and dated, fresh fruits should contain a received on date, and food would be discarded by the manufacturer's use by or sell by date. This deficiency represents non-compliance investigated under Complaint Number OH00154456.

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F 0839 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. 45441 Based on personnel file review and interview, the facility failed to ensure Licensed Practical Nurse (LPN) #1229 had an active and unrestricted nursing license prior to hire. This affected one of three personnel files reviewed for staff qualifications. This had the potential to affect all residents residing in the facility. The facility census was 81. Findings include: Review of the personnel file for LPN #1229 revealed a hire date of 05/14/24. There was no documented evidence LPN #1229's license was verified prior to starting work. Interview on 06/12/24 at 12:57 P.M. with the Administrator confirmed there was no documented evidence of licensure verification in LPN #1229's file. Review of the document titled License Look Up dated 06/21/24 and timed 1:13 P.M. confirmed LPN #1229 had an active and unrestricted nursing license.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, and facility policy review the facility failed to initiate and use transmission-based precautions (TBP) and enhanced barrier precautions (EBP) when appropriate for Residents #15, #56, and #179. This affected three residents (#15, #56 and #179) and had the potential to affect all 81 residents residing in the facility. Findings include: 1. Observation and interview on 06/10/24 at 9:18 A.M. with Resident #179 revealed a tracheostomy was in place. There was no EBP posted and no PPE (personal protective equipment) available near the room entrance. Review of the medical record for Resident #179 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure and tracheostomy status. The physician orders effective June 2024 and care plan dated 05/29/24 indicated tracheostomy care was required at least every shift and more often as needed. Observation on 06/12/24 at 10:43 A.M. with Registered Nurse (RN) #1266 and Licensed Practical Nurse (LPN) #1268 of tracheostomy care for Resident #179 revealed both nurses entered the room. There were no EBP posted and no PPE available near the room entrance. Gloves were donned after appropriate hand washing, and tracheostomy care was provided. No gowns were worn by either nurse. Interview at the time of the observation with RN #1266 and LPN #1268 verified no EBP were in place, and gowns were not worn during tracheostomy care as required. Review of the facility policy, Enhanced Barrier Precautions (EBP), dated March 2024, revealed EBP were used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities. EBP was indicated for residents with indwelling medical devices including tracheostomies. 39968 2. Resident #56 was admitted on [DATE] with diagnoses that included Alzheimer's disease, osteomyelitis, kidney disease, frontotemporal neurocognitive disorder, anemia, anxiety, and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was alert and oriented to person, place, and time. He had an unstageable wound (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) on the outside of his left heel. Observation on 06/11/24 at 1:15 P.M. of a dressing change for Resident #56 revealed he was not ordered to be under EBP due to his pressure wound. Interview on 06/11/24 at 1:15 P.M. with LPN #1268 revealed his wound was not considered chronic, so there was no EBP needed. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	43063 3. Review of medical record for Resident #15 revealed an admitted [DATE] with diagnoses including non-pressure chronic ulcer of the right foot, cellulitis (skin infection) of the left lower limb, diabetes mellitus, and peripheral vascular disease. Observation on 06/12/24 at 11:30 A.M. with RN #1275 of intravenous (IV) medication administration to Resident #15 revealed he had a central line venous catheter (a line that is inserted into a vein that leads to the heart). On Resident #15's door leading into the room there was a sign that stated he was on EBP that instructed staff to wear gown and gloves if there was device care including the use of central lines. During observation, RN #1275 performed hand hygiene, put gloves on, cleaned Resident #15's bedside table, removed her gloves, washed her hands, put gloves on, cleaned Resident #15's central line venous catheter tubing end and then flushed the central with 10 milliliters (mL) of normal saline. RN #1275 then hooked the central line venous catheter to the IV tubing that was attached to the antibiotics. At 11:45 A.M. RN #1275 verified she was aware Resident #15 was on EBP but thought it was for wound care only. She verified she had not followed the EBP for the device care. Review of the physician's orders for Resident #15 revealed an order for contact isolation every shift dated 05/31/24. There was no order for EBP. Review of the care plan dated 05/31/24 for Resident #15 revealed he had an infection of a wound requiring isolation. Interventions included to provide contact isolation. Review of the medication administration record (MAR) and treatment administration record (TAR) for Resident #15 for June 2024 revealed nursing staff had been signing off on each shift that Resident #15 should be in contact isolation. Review of the Resident #15's wound care progress note dated 06/03/24 revealed he had Methicillin-Resistant Staphylococcus Aureus (MRSA) (bacteria that is resistant to commonly used antibiotics) in the left medical lower leg wound and was on IV antibiotics for four weeks. Interview and observation on 06/12/24 at 1:27 P.M. with RN #1232 verified there was no sign on Resident #15's room alerting staff and visitors that he was in contact isolation. RN #1232 stated Resident #15 had MRSA in his wound that was covered by a wound vac. She stated he was a picker and she believed he had disconnected his wound vac at times as he is non-compliant. Review of the facility policy titled, Contact Precautions, revised March 2020, revealed gown and gloves should be worn when staff entered the room and removed before leaving the room when a resident was in contact isolation.