STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365634	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McCrea Manor Nsng and Rehab Ctr LLC	2040 McCrea Street Alliance, OH 44601

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on observation, medical record review, review of Self-Reported Incident, review of witness statement, policy review and interview, the facility failed to ensure staff provided appropriate dementia care when Resident #57, who had a diagnosis of dementia with mood disturbance/other behavioral disturbances and resided on the secured memory care unit, began to display resistive-to-care behaviors. This affected one (Resident #57) of three residents reviewed for dementia care. Sixteen residents (Residents #66, #62, #55, #52, #40, #57, #37, #49, #15, #68, #21, #45, #47, #41, #28 and #23) had a diagnosis of dementia and resided in the secured memory care unit. The census was 70. Findings include: Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses of Alzheimer's disease, dementia with mood disturbance, dementia with other behavior disturbances, and anxiety disorder. Resident #57's power of attorney (POA) was his wife. Resident #57 resided on the secured memory care unit. Review of Resident #57's care plan for impaired cognition dated 10/18/23 revealed Resident #57 had impaired cognitive function/dementia or impaired thought process with an intervention to communicate with Resident #57 and/or family/caregivers regarding his capabilities and needs. Review of Resident #57's care plan for inappropriate behaviors updated 02/13/24 revealed Resident #57 had verbally and physically aggressive behaviors at times related to diagnoses of Alzheimer's disease and dementia with behaviors. Behaviors included urinating in trash can, resistance to personal care, verbally and physically assaulting staff, removing clothing and wanting to walk around nude in the hallways with staff redirecting and assisting resident to redress. Inventions included approaching Resident #57 in a slow, calm manner, bringing resident to a quiet environment as needed, providing support and encouragement and allowing resident to make choices with daily care when possible. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #57 was severely cognitively impaired, had continuous inattention and disorganized thinking, utilized a wheelchair for mobility and required partial/moderate assistance with toileting and walking 150 feet. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing note dated 01/25/25 timed 11:17 P.M. revealed Resident #57 was aggressive with staff and other residents. It took three nurse aides to get Resident #57 back into his room as Resident #57 continued to try to hit, scream and yell. Resident #57 was taken into shower and continued to scream in shower with high pitched scream. Resident #57 took medications well after shower and was able to get calmed down and to room with no further incidents. Review of the Psychiatry Nurse Practitioner Note dated 01/30/25 revealed Resident #57 was last seen on 01/16/25 with a new order to discontinue Seroquel (an antipsychotic medication) 175 milligrams (mg) at bedtime and start Seroquel 150 mg at bedtime for seven days then 125 mg at bedtime. Nursing staff reported on 01/25/25 that Resident #57 was combative, and it took multiple nurses to get Resident #57 to room and his shower. The Assessment/Plan for anxiety/depression/dementia with behaviors indicated Resident #57 was to continue Namenda (a medication for treatment of Alzheimer's disease) 10 mg twice a day, paroxetine (an antidepressant) 20 mg, Depakote Sprinkles (used to treat mood conditions) 250 mg twice a day, Buspar (an antianxiety medication) 10 mg three times a day, Ativan (an antianxiety medication) 0.5 mg at bedtime and Ativan 0.5 mg every 24 hours as needed. At the last visit, gradual dose reduction (GDR) of Seroquel began. The note further indicated to continue decreasing Seroquel to 100 mg for seven days then to 75 mg. Resident #57 had an as needed available (Ativan), and would encourage use of as needed medication. Review of the physician orders from February 2025 revealed Resident #57 was ordered Ativan oral tablet 0.5 mg give one tablet by mouth every 24 hours as needed for agitation/anxiety. Review of the electronic medication administration record (eMAR) medication administration note dated 02/04/25 timed 9:50 A.M. revealed Resident #57 raised his fist and tried to hit the nurse when attempting to administer medications. Resident #57 refused and yelled, get the [expletive] out of here. Review of the nursing note dated 02/04/25 timed 7:04 P.M. revealed Resident #57 was going in and out of other resident rooms and got into an argument with another male resident. Resident #57 was hitting the nurse and nurse aides and was being very aggressive. Review of the eMAR medication administration note dated 02/10/25 timed 2:03 A.M. revealed Resident #57 began hitting and trying to bite an aide as she was trying to direct him to bed. The nurse interrupted and advised aide to step out of the room. Resident #57 was calm towards nurse and agreed to lay down in bed and let the nurse cover him up. Resident #57 stayed in bed with no further issues. Review of the Psychiatry Nurse Practitioner Note dated 02/13/25 revealed Resident #57 was last seen on 01/30/25 with a new order to decrease Seroquel to 100 mg for seven days then to 75 mg. Nursing staff reported Resident #57 had an incident with another resident and had been consistently having behaviors. The Assessment/Plan for anxiety/depression/dementia with behaviors indicated Resident #57 was utilizing Buspar 15 mg three times a day, Ativan 0.5 mg at bedtime and every 24 hours as needed, Namenda 10 mg twice a day, Seroquel 50 mg at bedtime and Depakote Sprinkles 250 mg at morning and 375 mg at bedtime. The note indicated the psychiatry nurse practitioner would continue to titrate Seroquel down because Resident #57 did not have the supporting diagnosis for the Seroquel medication. GDR of Seroquel 25 mg for seven days then discontinue. The note further indicated the nurse practitioner would like to increase Depakote Sprinkles to 250 mg three times a day. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the eMAR medication administration note dated 02/24/25 timed 3:44 A.M. revealed Resident #57 was wandering into other resident rooms. Resident #57 became agitated and tried to punch aides when they attempted to redirect. Resident #57 was directed to bedroom, medicated with bedtime medications, assisted to lay in bed, covered up, and bedroom door closed. Resident #57 stayed in room and eventually fell asleep. Review of the late entry health status note dated 02/28/25 timed 1:10 A.M. revealed Resident #57 was evaluated by the nurse to determine if any bruises or injuries were noted. No bruising/injuries were noted to resident face, neck or arms. Resident #57 would not allow the nurse to remove his shirt or pants to look for any bruising or injury. When asked if he had any pain anywhere, he replied, well no, nothing is bothering me. Review of the eMAR medication administration note dated 02/28/25 timed 4:07 A.M. revealed Resident #57 was wandering in other resident rooms, yelling at staff and was violent and aggressive with staff - hitting, punching and trying to bite staff. Interventions were one-to-one, reduction of stimulation and medication with bedtime medications that included Ativan. The note further indicated Resident #57 improved some, and would be violent and aggressive with staff whenever hands on care provided. Review of the February 2025 Medication Administration Record (MAR) revealed Resident #57 was not administered the as needed Ativan during the month. Review of the eMAR medication administration note dated 03/01/25 timed 2:08 A.M. revealed Resident #57 was fighting staff, trying to hit, kick and bite staff while they attempted to give him care. Resident #57 was wandering into other resident rooms and yelling at other residents. Resident #57 was directed to his room, bedtime medications were given and staff were able to get Resident #57 to lay down in his room and provided a quiet room with door shut. The note further indicated Resident #57 did calm down when left alone in room but continued to get up in the room, moved things around in room, urinated on the floor and tried to hit, kick and bite whenever staff tried to provide hands-on care. Review of the Psychiatry Nurse Practitioner Note dated 03/03/25 revealed psychiatric evaluation at the request of the facility staff for worsening of behaviors at bedtime and medication management. Wife reported Resident #57 told her, he is going to die. The note indicated Resident #57 was compliant with medications and review of the Medication Administration Record (MAR) indicated no use of as needed Ativan in over four weeks. Review of the nursing progress note dated 03/03/25 timed 8:40 P.M. revealed Resident #57 was walking around on unit searching for his room when he opened a door belonging to another resident. The other resident became angry and yelled at Resident #57 causing Resident #57 to go farther down the hall where he entered a different resident's room and that resident proceeded to tell him to get out and Resident #57 responded by telling the resident he would snap her neck. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the eMAR medication administration note dated 03/04/25 timed 12:54 A.M. revealed Resident #57 was wandering into other resident rooms, tried to lay in their beds, urinated all over his bedroom floor, and became violent with attempts of hands-on care. When staff was trying to redirect him out of another resident's room, Resident #57 became angry, started yelling, hitting and tried to bite staff. Other staff members took over care which did help Resident #57 calm down and they were able to get Resident #57 into bed to lay down. The note further indicated Resident #57 was currently asleep in bed and every 15 minute checks remained ongoing. Review of the March 2025 MAR revealed Resident #57 was not administered the as needed Ativan. Review of the February and March 2025 nursing and social services progress notes and assessments revealed there was no evidence the facility attempted to coordinate an interdisciplinary team meeting with Resident #57's wife regarding his increasing behaviors. Review of the Self-Reported Incident dated 02/27/25 revealed there was an allegation of physical and verbal abuse involving Resident #57. The MDS Nurse stated that a nurse aide who was training with two fell ow nurse aides accused the other two nurse aides of holding down Resident #57 and covering his mouth with their hand/hands. Review of the witness statement dated 02/27/25 authored by Certified Nurse Aide (CNA) #4 revealed, so at 8:40 P.M., myself and [CNA #3] and [CNA #2], we went into [Resident #57's] room and trying to change him but he was fighting us .and [CNA #3] was trying to put his brief on and [Resident #57] was fighting his legs . Interview on 03/03/25 at 2:15 P.M. with CNA #4 revealed on 02/27/25, it was her third day orienting with other CNAs and CNA #4 had been shadowing CNA #12 earlier in the day then began shadowing CNA #2 and CNA #3 on the memory care unit. At 8:40 P.M., Resident #57 was exiting his bedroom when CNA #2 and CNA #3 assisted him back into his bathroom within his bedroom. Resident #57 was yelling/screaming standing in front of the toilet saying get off of me while CNA #3 was behind him trying to apply an incontinence brief with CNA #4 assisting. CNA #2 or CNA #3 told Resident #57 to cooperate, we're trying to put your brief on then CNA #2 put her hand in front of his mouth so Resident #57 would not bite CNA #4. Interview on 03/03/25 at 2:51 P.M. with CNA #3 revealed on 02/27/25 around 9:30 P.M., CNA #4 asked for assistance to change Resident #57 because Resident #57's was wet/soiled and had incontinent odor so the CNAs assisted Resident #57 into his bathroom. At that time, Resident #57 grabbed CNA #4's wrists and tried to bite or hit her. CNA #3 held her hand between his mouth and shoulder to prevent him from biting CNA #4. The CNAs got his incontinence brief changed and assisted him to bed then notified Licensed Practical Nurse (LPN) #10 of what happened. CNA #3 stated that Resident #57's behaviors had been bad lately and he screamed when the staff tried to do any kind of care. Resident #57 would yell and reject care. Observation on 03/03/25 at 4:05 P.M. revealed Resident #57 was pleasantly sitting in a wheelchair in the dining room. Interview, during the observation, with Resident #57 revealed Resident #57 was unaware he was residing at a nursing home and unaware of the town where he resided. Interview on 03/03/25 at 4:20 P.M. with CNA #6 revealed Resident #57 had violent tendencies and was very violent. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/04/25 at 8:15 A.M. with LPN #8 revealed Resident #57 would often bite CNA #3 and LPN #8 had to patch up CNA #3's arms after being bit. Resident #57 sundowns (when behaviors occur in the afternoon and evening hours in people with dementia) and searched for his wife. Resident #57 got mad when redirected and re-approaching later did not work. However, if he was left alone and left to deescalate himself, he would lay down in bed. He got violent/yelled anytime the staff tried to perform care which was his way of acting out. Observation on 03/04/25 at 9:25 A.M. revealed Resident #57 was peacefully lying in bed with his eyes closed. Interview on 03/04/25 at 10:35 A.M. with CNA #2 revealed Resident #57 did not like to be touched, went into fight mode and would bite staff. On 02/27/25, the CNAs had been trying to assist him for five minutes in the bathroom beforehand when CNA #4 grabbed both his arms and pulled his sleeves over his hands then Resident #57 started swinging and biting CNA #4's arm stating, keep her away from me. Interview on 03/04/25 at 12:05 P.M. with Social Services Designee (SSD) #13 revealed Resident #57's wife used to come visit him from the morning into the afternoon every other day then the wife went on vacation for the last two to three weeks. Resident #57's behaviors had increased since the wife had not been coming in to visit. SSD #13 verified there had not been any documented formal interdisciplinary team meetings with Resident #57's wife to discuss his behavior management and dementia care. Interview on 03/04/25 at 12:45 P.M. and 3:05 P.M. with the Administrator verified there had not been an interdisciplinary team meeting including Resident #57's wife to discuss interventions that might be more successful in managing Resident #57's dementia related behaviors. The Administrator also verified Resident #57 was not administered as needed Ativan during February and March 2025 as suggested in the nurse practitioner progress note dated 01/30/25. Review of the facility's undated Dementia and Behavioral Health Guidelines policy revealed agitation referred to a range of behaviors associated with dementia, including irritability, sleeplessness and verbal or physical aggression. Agitation could be triggered by a variety of things, including environmental factors, fears and fatigue. Most often, agitation was triggered when the person experienced control being taken from him or her. Interventions included reducing noise, clutter or the number of people in the room. The policy indicated to try gentle touch, soothing music, reading or walking to quell agitation. Speak in a reassuring voice. Do not try to restrain the person during a period of agitation. This deficiency represents noncompliance investigated under Control Number OH00163161.