

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365634	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2025
NAME OF PROVIDER OR SUPPLIER McCrea Manor Nsng and Rehab Ctr LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653</p> <p>Based on medical record review and interview, the facility failed to honor Resident #3's choice in showers. This affected one (Resident #3) of three residents reviewed for resident rights</p> <p>Finding include:</p> <p>Review of Resident #3's open medical record revealed diagnoses including chronic kidney disorder, bipolar disorder, major depressive disorder, generalized muscle weakness, need for assistance with personal care and contracture. A care plan initiated 01/09/23 indicated Resident #3 needed assistance from staff to meet Activities of Daily Living (ADL) needs related to impaired mobility with decreased physical functioning and general debility following hospitalization with lymphedema and multiple wounds. Interventions included assisting Resident #3 with bathing as needed per resident's preference.</p> <p>A nursing note dated 03/15/25 at 11:51 P.M. indicated Resident #3 was offered a shower by staff during the shift. Resident #8 refused. The nurse spoke with Resident #3's Power of Attorney (POA) via Resident #3's personal cell phone about Resident #3 continuously refusing care and showers. The nurse explained to the POA that because Resident #3 continued to refuse showers/care his bed and linens had become extremely soiled. The nurse explained the POA/family would not be happy about Resident #3 being left in the condition he was in. The nurse went on to explain to the POA that staff would be getting Resident #3 up to be showered unless the POA stated otherwise. The nurse explained that if the POA were to say not to shower Resident #3 because he was refusing the nurse would chart the information. The POA stated she did not want it on the record that she was okay with Resident #3 laying in bed in his current stated and gave permission for the nurse and staff to shower Resident #3, clean and sanitize his mattress and change Resident #3's linen.</p> <p>A nursing note on 03/16/25 at 12:28 A.M. indicated Resident #3's shower was completed. Resident #3 tolerated the shower well.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #3 was able to make himself understood and was able to understand others. Resident #3 was assessed as cognitively intact. Disorganized thinking was present and did not fluctuate.</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 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A resident preference evaluation dated 04/03/25 at 11:44 A.M. indicated Resident #3 reported it was somewhat important to him to choose the type of bath he received. Resident #3 preferred a sponge bath. Resident #3 also indicated it was somewhat important to have his brother involved in discussion about his care.</p> <p>On 04/10/25 at 6:23 P.M., the nursing note from 03/25/25 regarding Resident #3 refusing a shower and the nurse reaching out to the POA to get permission to give a shower against his wishes when he was assessed as cognitively intact were discussed with the Administrator and Director of Nursing (DON). Neither voiced concerns regarding the note. The Administrator indicated staff could not just leave Resident #3 in bed unclean. The Administrator verified the power of attorney did not over-ride a resident's ability to make choices as long as the resident was able to make his own decisions. The Administrator stated Resident #3 had psychiatric diagnoses and might not be able to make good decisions. It was verified Resident #3 had not been deemed incompetent and did not have a guardianship assigned.</p> <p>On 04/10/25 at 8:40 A.M., Resident #3 was interviewed. When asked if he had any concerns about his care or how he was treated he stated he was taught by his parents at a young age not to report bad things against other people.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163934.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>22653</p> <p>Based on observation, medical record review, and interview, the facility failed to ensure ordered medication was available for administration. This affected three residents (Resident #15, #31, #32) of three residents reviewed for pharmacy services.</p> <p>Findings include:</p> <p>1. On 04/09/25 at 8:45 A.M., Licensed Practical Nurse (LPN) #100 was observed administering medication to Resident #31. As LPN #100 was preparing the medications she verified Resident #31 did not have Clopidrogel (anti-platelet) available for administration.</p> <p>2. Review of Resident #15's open medical record revealed diagnoses including type two diabetes mellitus with a foot ulcer, generalized muscle weakness, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), polyneuropathy, hyperlipidemia, morbid obesity, anxiety, depression, non-pressure chronic ulcer of the right foot, and protein-calorie malnutrition.</p> <p>Review of the March 2025 Medication Administration Record (MAR) revealed an electronic MAR note on 03/12/25 indicating Losartan Potassium, Amlodipine and another unspecified medication was not administered and waiting on pharmacy delivery.</p> <p>During an interview with the Director of Nursing (DON) on 04/09/25 at 3:28 P.M., the DON reported she had only worked at the facility for one week and she was unable to provide an explanation to those specific medications. However, she had been made aware of problems with the pharmacy.</p> <p>3. Review of Resident #32's medical record revealed diagnoses including epilepsy. Electronic MAR notes dated 02/09/25 at 10:45 P.M. 02/11/25 at 4:29 A.M., 02/12/25 at 6:49 A.M. and 02/12/25 at 8:31 A.M. indicated Phenobarbital (barbiturate) was not administered because it was not available. The note on 02/12/25 at 8:31 A.M. revealed the physician was aware and the facility was awaiting delivery from the pharmacy.</p> <p>On 04/15/25 at 4:20 P.M., the DON stated she was unable to explain why the Phenobarbital was not available during the time frame.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164119.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653</p> <p>Based on observation, review of physician orders, review of manufacturer information, policy review and interview, the facility failed to administer medication as ordered and/or in accordance with manufacturer guidance. Four medication errors out of 31 opportunities for error were identified resulting in a 12.9% error rate. This affected two (Residents #31 and #68) of six residents observed for medication administration.</p> <p>Findings include:</p> <p>1. Review of Resident #31's physician orders revealed Clopidrogel bisulfate 75 mg was ordered once a day in the morning. The start date was 02/15/25. Review of physician orders indicated an order dated 02/18/25 for one multivitamin every day in the morning, with no indication for minerals.</p> <p>On 04/09/25 Licensed Practical Nurse (LPN) #100 was observed preparing medication for administration to Resident #31 at 8:45 A.M. During the preparation, LPN #100 stated she had no Clopidrogel bisulfate (anti-platelet) 75 milligrams (mg) available for administration. LPN #100 verified she was preparing one multivitamin with mineral for administration. LPN #100 administered the multivitamin with mineral along with other medications. This resulted in two medication errors.</p> <p>2. Review of Resident #68's physician orders revealed an order dated 01/18/25 for one multivitamin every day. Resident #68 had orders for insulin Lispro dated 02/27/25 for 18 units before meals on a routine basis and for six units for a blood glucose level of 251-300.</p> <p>On 04/09/25 at 10:28 A.M., Registered Nurse (RN) #105 was observed preparing and administering medication to Resident #68. Among the medication administered was one multivitamin with mineral tablet. During the preparation stage, RN #105 verified she was preparing a multivitamin with mineral. At 10:38 A.M., RN #105 administered 24 units of insulin Lispro for a blood sugar level of 269. The Kwik-pen used did not have an open date recorded but was delivered to the facility on [DATE]. RN #105 was made aware the Kwik-pen did not have an open date on it prior to administration and the delivery date but administered it regardless. This results in two medications errors, to equal four total errors.</p> <p>Review of manufacturer information revealed the Kwik-pen should not be used for more than 28 days after the pen use started.</p> <p>Review of the facility's Medication Dispensing System policy (not dated) revealed instructions prior to medication administration, it should be verified the medication was the right drug, at the right dose, the right route, the right rate, the right time and for the right customer.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00164409, Complaint Number OH00164119, and Complaint Number OH00163930.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653</p> <p>Based on medical records, review of manufacturer information, observation and interview, the facility failed to ensure opened insulin pens were dated for proper use and disposal. This affected four residents (Resident #28, #46, #68, and #71) from two of three medication carts observed for medication storage.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During observation of medication preparation and administration on [DATE] between 10:28 A.M. and 10:38 A.M., Registered Nurse (RN) #105 was observed preparing and administering medication to Resident #68. RN #105 administered 24 units of insulin Lispro for a blood sugar level of 269. The Kwik-pen used did not have an open date recorded but was delivered to the facility on [DATE]. RN #105 was made aware the Kwik-pen did not have an open date on it prior to administration and the delivery date and acknowledged she agreed with the information shared. 2. On [DATE] at 10:28 A.M., RN #105 verified there was an undated opened insulin pen (Lantus) pen for Resident #46 and an undated opened Lantus Solostar pen for Resident #28 in the medication cart. 3. On [DATE] at 11:00 A.M., Licensed Practical Nurse (LPN) #145 verified there was an undated Lantus insulin pen in one of the medication carts for Resident #71. LPN #145 stated she did not know who Resident #71 was or how long ago he might have resided at the facility. LPN #145 indicated the insulin pen would need disposed of. <p>Review of progress notes for Resident #71 revealed he expired [DATE].</p> <p>Review of the facility's Medication Storage policy (not dated) indicated medications would be stored in the original, labeled containers received from pharmacy and expired, discontinued and/or contaminated medications were to be removed from the medication storage areas and disposed of in accordance with facility policy.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163930.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>22653</p> <p>Based on review of menus with spreadsheets, policy review, observation and interview, the facility failed to ensure appropriate portion sizes were served. This affected 33 residents with the potential to affect 69 of 70 residents in the facility as one resident (Resident #24) had an order for no food by mouth. The census was 70.</p> <p>Findings include:</p> <p>Review of the menu spreadsheet revealed four ounces of the rice pilaf was to be served except for those residents on carbohydrate controlled diets who were supposed to receive three ounces.</p> <p>Observations of the tray line on 04/07/25 at 11:15 A.M. revealed the facility was serving two ounces of rice pilaf. This was verified by [NAME] #120 at the time of the observation. [NAME] #120 was referred to the spreadsheet and verified the incorrect amount of rice pilaf had already been served.</p> <p>The facility identified Residents #2, #5, #6, #8, #11, #13, #14, #18, #21, #22, #23, #25, #27, #31, #32, #34, #35, #37, #39, #40, #48, #50, #53, #54, #55, #57, #59, #60, #62, #64, #65, #67, and #68 as those residents who received the inappropriate portion sizes of the rice pilaf.</p> <p>Review of the facility diet list revealed Resident #24 received no food by mouth.</p> <p>Review of the facility's Portion Control Guidelines (revised August 2008) revealed portion control shall be used to ensure nutritional adequacy of standardized recipes, positive nutritional status and cost control. Portion sizes shall be written on recipes, spreadsheets and production sheets. Portion control utensils shall be used during food preparation and service.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164119.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>22653</p> <p>Based on observation and interview, the facility failed to ensure food was served at a palatable, safe temperature. This affected one (Resident #37) of seven residents interviewed regarding the lunch meal served on 04/07/25.</p> <p>Findings include:</p> <p>On 04/07/25 between 11:15 A.M. and 12:02 P.M., the lunch tray line was observed. Incorrect information was provided to the surveyor regarding carts that had been served. At 12:02 P.M., the cook indicated she only had three trays left to serve but they were waiting on residents to indicate if they were going to the dining room or eating in their rooms. Meals were prepared and placed in the warmer.</p> <p>On 04/07/25 at 12:03 P.M., a test tray was prepared directly from the steam table. The temperature of the fish was 111 degrees Fahrenheit. [NAME] #120 stated the fish should have been 145 degrees when served. The fish tasted cool.</p> <p>On 04/07/25 at 1:53 P.M., Resident #37 reported she did not like the fish served for lunch. It was cold and did not taste good.</p> <p>Review of the facility's Food Temperature Guidelines (revised August 2008) revealed hot foods should be greater than 135 degrees at point of service.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164119.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>22653</p> <p>Based on review of medical records, policy review and interview, the facility failed to ensure medical records were complete to accurately reflect medications being administered or not. This affected two (Residents #15 and #17) of three residents reviewed for medication administration.</p> <p>Findings include:</p> <p>1. Review of Resident #15's open medical record revealed diagnoses including type two diabetes mellitus with a foot ulcer, generalized muscle weakness, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), polyneuropathy, hyperlipidemia, morbid obesity, anxiety, depression, non-pressure chronic ulcer of the right foot, and protein-calorie malnutrition.</p> <p>Review of the March 2025 Medication Administration Record (MAR) revealed no documentation of morning medications being administered on 03/13/25. Ordered medications included mag ox (supplement) 400 milligrams (mg), Fluoxetine (antidepressant) 40 mg, Buspirone (anti-anxiety) 10 mg, Pantoprazole sodium (used to reduce stomach acid production) 40 mg, Metformin (anti-diabetic) 750 mg, Meloxicam (non-steroidal anti-inflammatory drug) 7.5 mg, Losartan Potassium (used to treat high blood pressure 50 mg, iron-vitamins 325 mg, Aspirin 81 mg, and Amlodipine Besylate (used to treat high blood pressure) 5 mg.</p> <p>During an interview with the Director of Nursing (DON) on 04/09/25 at 3:28 P.M., the DON reported there was an agency nurse, identified as Registered Nurse (RN) #110, scheduled to work 03/13/25. RN #110 worked until 4:56 P.M. (time card provided) and was observed administering medications. However, after she left it was discovered she had not signed off the administration of medications on the MAR.</p> <p>2. Review of Resident #17's open medical record revealed diagnoses included multiple sclerosis, schizoaffective disorder, narcolepsy, chronic pain syndrome, protein-calorie malnutrition, obstructive sleep apnea, depression, dysphagia, epilepsy, seasonal allergic rhinitis, GERD, polyosteoarthritis, weakness and abnormal posture.</p> <p>Review of the February 2025 MAR revealed no documentation of morning medications including Riboflavin 100 milligrams ordered once a day, vitamin D 2000 units ordered every day, Zyrtec 10 milligrams ordered every day, Gauifenesin ER 600 milligrams ordered every 12 hours, Keppra (anticonvulsant) 500 milligrams ordered twice a day, Modafinil (central nervous system stimulant) 200 milligrams ordered twice a day, Senna S 8.6-50 milligrams (two tablets) ordered twice a day, Baclofen (skeletal muscle relaxant) 20 milligrams ordered three times a day, and Sucralfate (used to treat ulcers) 1 gram ordered three times a day) being offered or administered on 02/06/25. There was no documentation of medications scheduled to be administered on 02/06/25 at 2:00 and 3:00 P.M. being offered/administered, including Sucralfate 1 gram, Baclofen 20 milligrams, Senna S 8.6-50 mg (two tablets), and Modafinil 200 milligrams. There was no documentation indicating medications scheduled at bedtime on 02/11/25 were offered/administered, included Simvastatin used to treat high cholesterol) 10 milligrams (mg), Guaifenesin ER 600 mg, Keppra 500 mg, Baclofen 20 mg, and Sucralfate 1 gram.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/15/25 at 4:18 P.M., the DON stated she was unable to provide any additional details regarding why the medications were not documented as offered/administered.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164119.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>22653</p> <p>Based on observation and interview, the facility failed to maintain the environment in a clean and sanitary condition. This affected twelve residents (Resident #4, #8, #10, #15, #18, #23, #24, #27, #28, #36, #38, and #57) of fifteen resident rooms observed for cleanliness.</p> <p>Findings include:</p> <p>1. During observation of medication administration in Resident #27's room on 04/07/25 at 9:17 A.M., it was observed the floor was dirty. Resident #27 had a urinal on the floor under his bed. The stripping on the side of Resident #36's over bed table had pulled away from the surface on one long side of the table and 1/2 of one short side.</p> <p>On 04/07/23 at 9:23 A.M. Certified Nursing Assistant (CNA)/med tech #125 verified the table was in disrepair and stated the floor could be cleaner.</p> <p>On 04/07/25 at 9:50 A.M., the Administrator verified the environmental concerns identified in Resident #27's room.</p> <p>2. During observation of medication administration in Resident #24's on 04/09/25 at 9:37 A.M., a used toothette was observed on the floor near the trash can. A disposable glove was noted on the floor inside of the closet. Observations under Resident #24's bed revealed a ball of dust, a plastic bottle and a crayon. Resident #24 had a hair bush and paper under her bed. There was a plastic bag on the floor by the oxygen concentrator and a white substance on the floor in front of the night stand. The bathroom floor had one lighter area of brown between the toilet and doors which appeared to be the original coloring of the floor. The remainder of the flooring was dark. There was build up of dirt around the bolts at the base of the toilet.</p> <p>On 04/07/25 at 9:45 A.M. the environmental concerns were brought to the attention of Registered Nurse (RN) #105 who did not dispute the findings. RN #105 stated she was unaware of the facility's cleaning schedule.</p> <p>On 04/07/25 at 9:50 A.M., the Administrator verified the environmental concerns identified in Resident #24's room.</p> <p>3. On 04/07/25 at 10:57 A.M., Resident #15 stated she did not feel the room and bathroom floors were kept clean. Observations at that time revealed along the edges of the bathroom flooring, flooring under the sink in the room and along the edges of the room were discolored.</p> <p>4. On 04/09/25 at 9:20 A.M. , a discoloration of the flooring between the beds and doors in Resident #38 and Resident #57's room was noted. The areas appeared to be a dried spill. In Resident #8's room there was one large piece and multiple smaller shredded pieces of an incontinence brief on the floor.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/09/25 at 9:50 A.M., the environmental concerns in Resident #38, Resident #57, and Resident #8's rooms were verified by the Administrator who stated housekeeping might not have cleaned those rooms yet. The Administrator verified staff should clean spills and pick up trash regardless of their titles. The Administrator called for a housekeeper.</p> <p>5. On 04/09/25 at 10:17 A.M., an over-bed table was inside the doorway of Resident #23 and Resident #28's room with the strip on the side of the table taped. This was verified by the Administrator at that time, who instructed staff to remove and replace the table. It was unknown whose table was taped.</p> <p>6. On 04/09/25 at 10:57 A.M. observation and interview with the Administrator verified the bathroom floor between Resident #8 and Resident #10's rooms were stained and there was a build up of dirt around the toilet bolts.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164119 and Complaint Number OH00163934.</p>