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	03/25/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview, record review, and facility policy review, the facility failed to ensure physician orders were followed timely. This affected one resident (#70) of three residents reviewed for quality of care. The facility census was 65.Findings include:Review of the closed medical record for Resident #70 revealed an admission date of 02/19/25 and a discharge date of 03/04/26. Diagnoses included but not limited to age related osteoporosis, hypertensive heart and chronic kidney disease with heart failure stage 3, COPD, type 2 diabetes mellitus, multiple fractures of ribs, right side, of right ulna styloid process, nondisplaced fracture of shaft of right radios, and protein-calorie malnutrition.Review of the handwritten physician orders dated 02/17/26 for Resident #70 revealed an order for one (1) Liter (L) of Normal Saline (NS) 100 cubic centimeters per hour (CC/HR) of Intravenous fluids. The handwritten order was signed by Licensed Practical Nurse (LPN) # 202 and dated 02/18/26.Review of the medication administration records (MARS) and treatment administration records (TARS) for Resident #70 for 02/18/26 revealed an order for Normal Saline Flush Intravenous Solution 0.9% (Sodium Chloride Flush) use 1 liter IV every 24 hours for dehydration until 02/19/26 run at 100 milliliter (ML) per hour start date of 02/18/26 at 6:30 P.M. was administered by Registered Nurse (RN) #204.Review of the progress notes dated 02/18/26 at 6:38 P.M., authored by RN #204, for Resident #70 revealed the peripheral IV was initiated to resident's left antecubital space. NS running at 100 milliliter/hour (ML/HR), (ML/HR and CC/HR are used interchangeably), 22 gauge needle catheter in place. Interview on 03/18/26 at 2:01 P.M. with RN #204 revealed an order for IV fluids were to be hung for Resident #70 and the two nurses prior to her refused to hang the IV and the Director of Nursing (DON) told the nurse they had to hang it.Interview on 03/19/26 at 1:48 P.M. with DON denied any knowledge of instructing RN #204 or any nurse to put in IV for Resident #70. DON denied any knowledge of nurses refused to start an IV and administer IV fluids per physician orders. DON confirmed Resident #70's IV infusion order was not initiated timely on 02/18/26, but RN #204 had all day on 02/18/26 to start the IV and administer IV fluid per physician orders. Interview on 03/19/25 at 5:25 P.M. with LPN #202, via phone, revealed she might have taken the IV order for Resident #70, but dayshift nurse was to start the IV. LPN #202 confirmed she worked on 02/17/26 midnight shift from 7:00 P.M. to 7:00 A.M. on 02/18/26.Interview on 03/23/26 at 12:19 P.M. with Interim DON #300 confirmed Resident #70's IV of NS was not timely administered. Interim DON #300 confirmed timely IV administration would be a few hours after the order was received. Interview on 03/24/26 at 10:05 A.M. with Assistant Director of Nursing (ADON) #219 denied any knowledge of instructing a nurse to put in an IV for Resident #70. ADON #219 denied any knowledge of nurses refusing to start an IV and administer IV fluids per physician orders. ADON #219 confirmed Resident #70's IV infusion order was not initiated timely on 02/18/26. Review of the facility policy, Physician Orders Policy and Procedure, revised 05/2025, revealed the purpose of this policy is to provide guidance for licensed nurses to accurately document physician and provider orders. Further states, the nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse.This deficiency represents non-compliance investigated under Complaint Number 2798999.

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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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** Based interview, observation, record review, and facility policy, the facility failed to ensure smoking supplies were locked and secured. This affected one (Resident #62) out of three residents reviewed for smoking. The facility census was 65.Findings include:Review of the medical record for Resident #62 revealed an admission date of 03/04/21 with diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, acute chronic respiratory failure with hypoxia, epilepsy, chronic obstructive pulmonary disease (COPD), alcohol abuse, cannabis use, and tobacco use.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #62 had intact cognition.Review of the care plan for Resident #62 dated 02/13/26 revealed he is at risk for injury related to smoking, cigarettes and electronic device. Interventions included supervision at all times while smoking, smoking apron to be worn while smoking, and smoking items to be kept at the nurses station. Observation on 03/18/26 at 10:49 A.M. of Resident #62 revealed he was in bed with oxygen on per nasal cannula. On his over the bed tray next to his bed was a metal red box opened and in it was a disposable e-cigarette called a vape. Resident #62 confirmed he keeps it in his room in the red box. Interview on 03/18/26 at 10:52 A.M. with Certified Nursing Assistant (CNA) #246 confirmed Resident #62 had his e-cigarette vape in his room in the opened red metal box. Interview on 03/18/26 at 10:53 A.M. with CNA #226 confirmed Resident #62 had his e-cigarette vape in his room and wasn't permitted to have in his room.Interview on 03/18/26 at 12:58 P.M. with Director of Nursing (DON) confirmed Resident #62 was not permitted to keep his e-cigarette supplies in his room. Review of the facility policy, Lionstone Smoking, revised 10/15/24 revealed no smoking materials are permitted with the resident or in their room. All smoking materials cigarettes, cigars, lighters, vapes etc, must be kept in lock boxes at the nurse station or designated area (Per State Regulations). This deficiency represents non-compliance investigated under Complaint Number 2797255.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy, the facility failed to ensure narcotic medications were administered per physician orders and reconciled properly. This affected one resident (Resident #71) of three residents reviewed for medications. The facility census was 65. Findings include:1.Review of the medical record for Resident #71 revealed an admission dare of 01/29/26 and a discharge date of 02/26/26 to home with diagnoses including but not limited to encephalopathy, low back pain, spinal stenosis cervical region and anxiety.Review of the care plan dated 01/29/26, revealed Resident #71 was at increased risk of adverse reactions related to taking opiates. Interventions included to administer medications as ordered by physician and monitor for side effects of medication.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had intact cognition. Review of physician orders dated for February 2026, revealed Resident #71 was ordered Klonopin (Clonazepam), 0.5 milligram (mg) give one (1) tablet by mouth (PO) two times a day (BID) for anxiety. Review of the medication administration records (MARS) and treatment administration records (TARS) for February 2026 revealed on 02/01/26 the morning dose (AM) dose, 02/02/26 the morning and evening dose, and on 02/16/26 the morning and evening dose for Clonazepam 0.5 mg had a number nine placed in the box to indicate not given and number nine was a code to Other/See Nurses Notes. Review of the narcotic sign out sheet for February 2026 revealed Clonazepam 0.5 mg was not signed out for the above doses. Review of Resident #71's progress notes revealed there was not a note for 02/01/26 regarding Klonopin 0.5 mg not being administered.Review of the progress note dated 02/02/26 at 9:02 A.M. revealed Klonopin 0.5 mg was not administered due to awaiting from pharmacy and the nurse practitioner was notified of the need for a refill.Review of the progress note dated 02/16/26 at 9:36 P.M. revealed Klonopin 0.5 mg was not administered due to waiting on new prescription.Interview on 03/23/26 at 1:44 P.M. with Interim Director of Nursing (DON) confirmed Resident #71 did not receive her Clonazepam 0.5 mg on 02/01/26 in the morning, 02/02/26 morning and evening dose, and on 02/16/26 morning and evening. Interim DON confirmed five doses of Clonazepam were missed.Review of facility policy, Administering Medications, revised 04/28/25, revealed medication shall be administered in a safe and timely manner, and as prescribed accordance with the orders.2. Review of the narcotic sign out sheet for Resident #71 revealed Clonazepam 1 mg available and order for Clonazepam 0.5 mg to be administered BID. The narcotic sign out sheet dated 02/18/26 at 10:00 A.M. revealed Registered Nurse (RN) #204 wasted Clonazepam 0.5 mg and signed for it. There was no second witness signature as required.Review of the Narcotic Sign out sheet for Resident #71 revealed Clonazepam 1 mg available and order for Clonazepam 0.5 mg to be administered BID. The narcotic sign out sheet dated 02/19/26 at 09:15 A.M. revealed RN #251 wasted Clonazepam 0.5 mg and signed for it. There was no second witness signature.Interview on 03/23/26 at 1:44 P.M. with Interim Director of Nursing (DON) confirmed Resident #71 was ordered Clonazepam 0.5 mg was to be administered BID. DON confirmed the narcotic sign out sheet for 02/18/26 at 10:00 A.M. and on 02/19/26 at 09:15 A.M. had only one signature for the wasted medication of Clonazepam 0.5 mg. DON confirmed the wasted narcotic medication was to have two witnesses and two signatures of the wasted narcotic medication.Interview on 03/24/26 at 9:49 A.M. via phone, with RN #251 confirmed Resident #71 had Clonazepam 1 mg available with an order for Clonazepam 0.5 mg. RN #251 confirmed there should have been two witnesses and two signatures when the medication was wasted. RN #251 reported she always had a witness and couldn't remember why there was only one and reported maybe the other nurse walked away and didn't sign. Interview on 03/24/26 at 1:56 P.M. with RN #204 confirmed Resident #71's Clonazepam 1 mg available and order for Clonazepam 0.5 mg. RN #204 confirmed there was only her signature when the medication was wasted but should have had two nurses witness the wasting of narcotic medication, with two signatures. RN #204 reported at (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the time she wasn't aware she needed 2 nurses to witness and sign.Review of the facility policy, Schedule 2 Controlled Substance Medication, undated, revealed the policy is to ensure adherence to state and federal laws related to the dispensing of Schedule 2 Controlled substance medications. Further stated waste of controlled dangerous substance will include all medication destruction in the facility shall be witnessed by at least two person, each of whom shall be registered professional nurse or a licensed practical nurse. A record of each drug destruction shall be maintained.