STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365685	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Neill Healthcare North Ridgeville	38600 Center Ridge Rd North Ridgeville, OH 44039

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on medical record review, pharmacy recommendation review, and staff interview, the facility failed to ensure pharmacy recommendations were addressed in a timely manner. This affected two (#73 and #117) of five residents reviewed for unnecessary medications. The facility census was 133. Findings include: 1. Review of the medical record for Resident #73 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, diabetes mellitus, and generalized anxiety disorder. Review of the pharmacy recommendation dated 04/29/24 revealed Resident #73 was receiving Lantus insulin five units twice daily with blood sugar fluctuating from normal to elevated. Further review revealed the pharmacist recommended a hemoglobin A1C laboratory value be obtained and consider increasing Lantus if appropriate. The physician marked the box on the document that indicated agreement with the recommendation, signed the document, and dated it 05/13/24. Review of Resident #73's medical record revealed no hemoglobin A1c laboratory results were obtained at the time of the review on 09/18/24. Interview on 09/18/24 at 1:12 P.M. and on 09/19/24 at 7:30 A.M. with the Director of Nursing (DON) stated Resident #73 did not always allow laboratory draws, so the facility usually tried to do any additional laboratory draws with other routine laboratory draws. The DON verified he was unable to find the laboratory result or documentation that the physician wanted the hemoglobin A1c to be drawn with the next routine laboratory draw which was today at the time she addressed the recommendation. 2. Review of the medical record for Resident #117 revealed an admitted [DATE]. Diagnoses included major depressive disorder, peripheral vascular disease, and personal history of nicotine dependence. Review of the pharmacy recommendation dated 05/30/24 revealed Resident #117 had an order for a nicotine patch without titration with a recommendation to add a stop date to nicotine 21 milligrams (mg) per day for six weeks total, followed by 14 mg per day for two weeks, then finish with seven (7) mg per day for two weeks. Further review revealed the physician agreed with the recommendation, documented V.O. (verbal order), and signed and dated the form 09/17/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #117's physician's order for September 2024 revealed active orders dated 09/17/24 for a nicotine transdermal patch 21 mg per 24 hours for seven days with a start date of 09/18/24 and an end date of 09/25/24; a nicotine transdermal patch 14 mg per 24 hours for seven days with a start date of 09/26/24 and an end date of 10/03/24; and a nicotine transdermal patch 7 mg per 24 hours for seven days with a start date of 10/04/24 and an end date of 10/11/24. Interview on 09/18/24 at 1:12 P.M. with the DON verified the pharmacy recommendation for Resident #117 dated 05/30/24 was missed and the titration order was written on 09/17/24. The DON stated it was not related to the pharmacy recommendation; the physician decided to do the titration on her own. The DON stated he did not know about the pharmacy recommendation until today. Review of the policy titled, Medication Regimen Review, dated 10/01/18, revealed for non-urgent recommendations, the facility and attending physician must address the recommendation(s) in a timely manner that meets the needs of the resident but no later than their next routine visit to access the resident and the attending physician should document in the medical record, what irregularity has been reviewed, what actions has been taken to address the issue, and the pharmacy recommendation itself can be used as a tool to document in the medical record, or a notation may be indicated in the medical record/EHR.