STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366187	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minerva Rehabilitation and Nursing Center	1035 East Lincolnway Minerva, OH 44657

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 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 record review and interview, the facility failed to ensure Resident #27's Gabapentin medication was not administered to Resident #21. This finding affected two (Residents #21 and #27) of six residents reviewed for medication administration. Findings include: Review of Resident #21's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including encounter for orthopedic aftercare, cerebral palsy and anxiety disorder. Review of Resident #21's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #21's physician orders revealed an order dated [DATE] for Gabapentin oral tablet 800 mg (milligrams) give one tablet by mouth four times a day for 120 days due at 12:00 A.M., 6:00 A.M., 12:00 P.M. and 6:00 P.M.; and an order dated [DATE] to give Gabapentin 600 mg one time only for nerve pain for one day. Review of Resident #21's progress note dated [DATE] at 3:03 P.M. authored by Licensed Practical Nurse (LPN) #809 revealed it was okay to give a one-time dose of 600 mg of Gabapentin as ordered by the physician. Review of Resident #21's progress note dated [DATE] at 3:13 P.M. authored by LPN #809 revealed the Gabapentin oral tablet 800 mg due at 12:00 P.M. was held and a one-time only dose of 600 mg was administered to the resident. The physician was aware. Review of Resident #21's medication administration records (MARS) from [DATE] to [DATE] revealed the medications were administered as ordered. Review of Resident #27's medical record revealed the resident was admitted on [DATE] and expired in the facility on [DATE] with diagnoses including hemiplegia, chronic obstructive pulmonary disease and bipolar disorder. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's physician orders revealed an order dated [DATE] (discontinued [DATE]) for Gabapentin 600 mg give one tablet by mouth three times a day; and an order dated [DATE] for Gabapentin 600 mg give one tablet by mouth four times a day. Interview on [DATE] at 9:16 A.M. with Licensed Practical Nurse (LPN) #809 revealed she administered 600 mg of Gabapentin to Resident #21 on [DATE] at 12:00 P.M. and the dose should have been 800 mg. LPN #809 confirmed she called the physician and obtained a one-time order for the 600 mg of Gabapentin for the resident's nerve pain. A second interview on [DATE] at 10:16 A.M. with Director of Nursing (DON) #830 and LPN #809 confirmed LPN #809 administered Resident #27's Gabapentin to Resident #21 on [DATE]. The nurse stated this was done in error. This violation represents non-compliance investigated under Complaint Number OH00164228.