STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365163	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northcrest Rehab and Nursing Center	240 Northcrest Drive Napoleon, OH 43545

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, and review of facility policy, the facility failed to ensure fingernails were kept cleaned and trimmed on a dependent resident. This affected one resident (#2) of one resident reviewed for clean and trimmed nails. The facility census was 62. Findings include: Review of the medical record for Resident #2 revealed he was admitted on [DATE] with diagnoses of cerebral vascular accident (CVA - stroke) with left sided hemiplegia and hemiparesis (weakness and paralysis). Review of the annual Minimum Data Set (MDS) dated [DATE] for Resident #2 revealed he had moderate cognitive impairment and was dependent on staff for personal hygiene. Review of the care plan revised 01/25 for Resident #2 revealed the resident is care planned for self-care deficit due to CVA with left sided hemiplegia and was dependent on staff for personal hygiene. Review of the shower sheets dated 01/02/25 for Resident #2 revealed he had a bed bath per his preference and his fingernails were cleaned and trimmed. Further review of the shower sheets dated 01/09/25 and 01/16/25 for Resident #2 revealed he had his bed bath and his fingernails were cleaned but not trimmed. Review of the Certified Nursing Assistant (CNA) documentation for the past 30 days for Resident #2 revealed he did not have any rejection of care. Observation on 01/21/25 at 11:03 A.M. of Resident #2 revealed his fingernails were long and approximately one quarter to one half inch in length beyond the tip of his finger and under the nail was dirty with black and yellow caked under the nails especially under the right thumb nail. Observation on 01/22/25 at 9:05 A.M. of Resident #2 revealed his fingernails remained long and dirty. Interview on 01/22/25 at 11:07 A.M. with Certified Nurse Aide (CNA) #634 verified the long and dirty fingernails on Resident #2. (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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Care of Fingernails/Toenails, dated 10/10, revealed the purpose of the procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care includes daily cleaning and regular trimming.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, observation, interview, and policy review, the facility failed to apply brace/splint per physician order. This affected one (#55) of one resident reviewed for position and mobility. The facility census was 62. Findings include: Review of the medical record for Resident #55 revealed an admitted [DATE] with diagnoses including but not limited to traumatic subdural hemorrhage with loss of consciousness, gastrostomy status, displaced fracture of second cervical vertebra, tracheostomy status, presence of other vascular implants and grafts, and anemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had severe cognitive impairment and was dependent on staff for activities of daily living. Review of current physician orders revealed left lower extremity PRAFO brace on in the morning and off at bedtime, passive range of motion to upper and lower extremities, rolled up wash cloth in right and left hand, remove every six hours and check skin integrity. Review of care plan dated 01/09/25 revealed Resident #55 had an activities of daily living self-care performance deficit related to disease process. Interventions included left lower extremity brace, ensure resident has sock on prior to placing brace, put on in the morning and remove at bedtime and check skin integrity with application and removal. Review of the Treatment Administration Record (TAR) for January 2025 revealed wash cloth to right hand, wash cloth to left hand, and PRAFO boot were signed off as completed on 01/21/25 and 01/22/25. Observation on 01/21/25 at 1:52 P.M. of Resident #55 in bed revealed no splints or braces on at this time. Bilateral soft heel boots observed on resident. No wash cloths or splints observed in bilateral hands. Observation on 01/22/25 at 9:00 A.M. of Resident #55 in bed revealed bilateral soft heel protector boots in place. No splint or wash clothes in bilateral hands. No PRAFO boot on left lower extremity. Interview on 01/22/25 at 9:26 A.M. with Certified Nursing Assistant (CNA) #642 verified Resident #55 did not have on a splint or any wash clothes in either hand. CNA #642 stated the resident did not have any splints. CNA #642 stated the resident only had a boot that she wears at night and a belly band that she is aware of. CNA #642 pulled the boot from the chair under a pillow to show the surveyor and placed the boot back on the chair. Follow-up observation on 01/22/25 at 10:04 A.M. of Resident #55 revealed PRAFO boot now on left foot and wash rag observed in left hand. No wash cloth observed in the right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation on 01/23/25 at 9:13 A.M. of Resident #55 revealed PRAFO boot on left foot, towel in left hand and nothing in right hand at this time. Review of policy titled, Rehabilitative/Functional Maintenance Nursing Care, not dated, revealed rehabilitative nursing care is performed daily for those residents who require such service. Such program includes, but is not limited to assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests and others as prescribed by the resident's attending physician.

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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** 37451 Based on observation, record review, staff interview, and review of facility policy, the facility failed to ensure fall interventions were implemented. This affected two residents (#15 and #48) of two residents reviewed for falls. The facility census was 62. Findings include: 1. Review of Resident #15's medical record revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis, osteoarthritis, cerebral infarction, and convulsions. Review of Resident #15's Minimum Data Set (MDS) 12/27/24 revealed a Brief Interview for Mental Status (BIMS) score of 10 indicting Resident #15 was moderately cognitively impaired. Resident #15 was dependent on staff for toilet use, parts of dressing, bed mobility, and transfer. Resident #15 required maximal assistance with bathing. Resident #15 displayed verbal behavioral symptoms directed towards others one to three days during the review period. Review of Resident #15's care plan revised 12/27/24 revealed supports and interventions in place for risk for falls. Fall interventions included providing safe environment including personal items in reach, two assist with transfer, nonskid strips applied by bed, in-front of the recliner, and next to the recliner, call light in reach, Dycem on wheelchair, encourage hipsters and nonskid socks. Additionally, on 03/03/16 an intervention was noted for Resident #15's bed to be in the lowest position and the wheels locked. Observation on 01/21/25 at 9:41 A.M. found Resident #15 lying in bed with her head and her right arm partially hanging over the side of the bed. Resident #15's bed was not in a low position and skid strips were not observed to be in front or on the floor to the right side of the recliner. Observation on 01/22/25 at 9:03 A.M. of Resident #15 found her lying in bed with her head and right arm hanging over the right side of the bed. Resident #15's bed was not in a low position and skid strips were not observed to be in front or on the floor to the right side of the recliner. Interview on 01/22/25 at 9:15 A.M. with Certified Nursing Assistant (CNA) #668 reported Resident #15 was at risk for falls and one of her interventions was to be in a low bed. An observation of Resident #15 was made with CNA #668 and CNA #668 verified Resident #15's bed was not in the lowest position. CNA #668 was observed asking Resident #15 if she would allow her to adjust her in the bed and Resident #15 declined. CNA #668 then proceeded to lower Resident #15's bed to the lowest position. Interview on 01/22/25 at 11:53 A.M. with CNA #772 verified there were no skid strips next to or in front of the recliner. Follow up observation and interview on 01/22/25 at 1:35 P.M. with Assistant Director of Nursing (ADON) #718 found clear nonskid strips had been applied to the floor next to Resident #15's bed and verified there were none in front of or next to the recliner. ADON #718 reported Resident #15's room had been rearranged when a bed was added. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47057 2. Review of the medical record for Resident #48 revealed she was admitted on [DATE] with diagnoses of history of falling and dementia. Review of the annual MDS dated [DATE] for Resident #48 revealed she was cognitively impaired and has had falls since her admission. Review of the care plan revised 10/24 for Resident #48 revealed she was at risk for falls and had the following interventions: touch pad call light, non-skid strips applied to the end of the roommate's bed and non-skid strips applied to the left side of the bed. Observation on 01/22/25 at 11:15 A.M. of Resident #48's room revealed the call light was a regular push button type call light and not a touch pad style call light, there were no non-skid strips at the foot of the roommate's bed or to the left side of Resident #48's bed. Interview on 01/22/25 at 11:19 A.M. with Licensed Practical Nurse (LPN) #770 verified the call light for Resident #48 was a regular push button type of call light and not a touch pad type of call light, and there were not any non-skid strips to either the foot of the roommate's bed or to the left side of the bed for Resident #48. LPN #770 further stated Resident #48 had recently changed rooms. Observation of the previously occupied room for Resident #48 revealed there were no non-skid strips to the floor in the old room. Review of the facility policy titled, Managing Falls and Fall Risk, revised December 2007, revealed based on evaluations and current data the staff would identify interventions related to the resident's specific risks and causes to try and prevent the resident from falling.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, medical record review, staff interview, resident interview, and review of facility policy, the facility failed to ensure medications were stored in a proper manner. This affected two (Residents #22 and #16) of two residents observed for medication storage. The facility census was 62. 1. Review of the medical record for Resident #22 revealed an admitted [DATE] and a readmitted [DATE] with diagnoses of chronic obstructive pulmonary disease and dementia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #22 had impaired cognition. Review of the Self-Medication Assessment, completed 12/04/24, revealed Resident #22 was unable to self-administer medications. Observation on 01/21/25 at 9:20 A.M. revealed a bottle of aspirin, dose 325 milligrams (mg), lying on top of Resident #22's bedside cabinet. Resident #22 was not in the room during the observation. Interview and observation on 01/21/25 at 9:24 A.M. with Unit Manager (UM) #700 confirmed bottle of 325 mg aspirin was on Resident #22's bedside cabinet. UM #700 stated Resident #22 was not able to self-administer medications and removed the bottle of aspirin from Resident #22's room. Interview on 01/23/25 at 7:36 A.M. with Resident #22 revealed she purchased the aspirin at a local store. Resident #22 stated she was aware she was not allowed to have medication in her room. Resident #22 stated she planned to crush up the aspirin and apply it to her face to help with acne. Interview on 01/23/25 at 11:14 A.M. with UM #700 revealed Resident #22's bottle of aspirin was unopened, and was labeled and stored in the medication room. UM #700 stated she spoke with Resident #22 who wished to use the aspirin as a skin treatment for acne. UM #700 stated she had not yet spoken with the physician regarding Resident #22's request to use aspirin for a skin treatment. Review of the policy titled Administering Medications, revised 04/19, revealed medications are administered in a safe manner. Review of the policy titled Storage of Medications, revised 04/19, revealed the facility stores all drugs and biological's in a safe, secure, and orderly manner. 47057 2. Review of the medical record Resident #16 revealed she was admitted on [DATE] with diagnoses of ovarian and breast cancer. Review of the quarterly MDS dated [DATE] for Resident #16 revealed she had mild cognitive impairment. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Self-Medication assessment dated [DATE] for Resident #16 revealed she is not able to self-administer medication. Observation on 01/21/25 at 9:37 A.M. of Resident #16 revealed she was sitting on her bed and her overbed table was in front of her, on the overbed table was a medication cup containing four unidentified medications, one round red pill, one white oblong pill, and two small round white pills. Interview on 01/21/25 at 9:43 A.M. with Registered Nurse (RN) #648 verified the medication cup was left unattended at the bedside with four unidentified pills in the medication cup. RN #648 further stated Resident #16 stated she didn't want to take them all and so she left them for her to take and she would check back to make sure she took the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, staff interview, record review, and review of the facility policies, the facility failed to ensure proper infection control practices were implemented related to COVID-19 droplet isolation and contact isolation. This affected four (#37, #28, #56 and #12) residents and had the potential to affect all 29 residents on the 300 and 400 halls (#1, #2, #3, #4, #7, #9, #10, #13, #16, #18, #20, #22, #26, #27, #30, #34, #36, #40, #41, #42, #44, #45, #46, #47, #48, #49, #51, #58, and #163). The facility census was 62. Findings include: 1. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses of vascular dementia and COVID-19 (initiated 01/13/25). Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 had intact cognition. Review of a current physician order dated 01/13/25 revealed Resident #37 was in droplet isolation for COVID-19 with all services to be provided in the room. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses of spinal cord cancer and chronic respiratory failure. Review of the quarterly MDS assessment dated [DATE] revealed Resident #28 had impaired cognition. Observation on 01/21/25 at 11:28 A.M. revealed signage posted outside Resident #37's room indicating he was in droplet precautions and staff should wear an N95 mask, a gown, and disposable gloves prior to entering the room. Additional signage revealed staff should remove all PPE before exiting the room, perform hand hygiene, and use a new N95 upon exiting the room. Observation on 01/21/25 at 11:30 A.M. revealed CNA #771 wearing an N95 mask and carrying a meal tray toward Resident #37's room. CNA #771 stopped outside the room and put on a disposable gown, did not put on gloves, and entered Resident #37's room. Continued observation from the open doorway revealed CNA #771 set the meal tray on Resident #37's overbed table, uncovered the plate, spoke with Resident #37, covered the plate and began to exit the room. CNA #771 removed the gown and disposed of it in a trash bag that was resting on the floor by holding the bag open with one ungloved hand and putting the soiled gown into the bag. CNA #771 exited Resident #37's room without removing or changing his N95 mask. CNA #771 did not perform hand hygiene before he observed Resident #28's call light was on and proceeded across the hall to provide care to Resident #28. Observation from the hall revealed CNA #771 rubbing Resident #28's legs and providing reassurance. CNA #771 then covered Resident #28 with a blanket and left the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/21/25 at 11:34 A.M. with CNA #771 confirmed he did not wear gloves upon entering Resident #37's room with the meal tray and did not perform hand hygiene upon exiting the room before entering Resident #28's room. CNA #771 stated he was not aware he needed to wear gloves when providing meal trays. CNA #771 further confirmed he did not change his N95 mask upon exiting Resident #37's room and before entering Resident #28's room and providing care. CNA #771 was unaware Resident #37 was in droplet precautions for COVID-19. 2. Review of the medical record for Resident #56 revealed an admitted [DATE] with diagnoses of COVID-19 (01/20/25), and Alzheimer's dementia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #56 had severely impaired cognition and required supervision or touching assistance with eating. Review of the current physician order dated 01/20/25 revealed Resident #56 was in droplet isolation for COVID-19. Observation on 01/21/25 at 11:40 A.M. revealed a sign posted outside Resident #56's room indicating he was in droplet precautions and staff should wear an N95 mask, a gown, and disposable gloves prior to entering the room. Additional signage revealed staff should remove all PPE before exiting the room, perform hand hygiene, and use a new N95 upon exiting the room. Observation on 01/21/25 at 11:44 A.M. revealed CNA #771 entering Resident #56's room without donning PPE and pulling the curtain closed around Resident #56's bed. Observation and interview on 01/21/25 at approximately 11:45 A.M. with Licensed Practical Nurse (LPN) #664, who donned a disposable glove and pulled back the curtain around Resident #56's bed, revealed CNA #771 sitting next to Resident #56's bed wearing an N95 but no gloves or gown. CNA #771 was preparing to assist Resident #56 with eating his meal. LPN #664 directed CNA #771 to don a gown and gloves before continuing to assist Resident #56. 3. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses of type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue, and morbid obesity. Review of the quarterly MDS assessment dated [DATE] revealed Resident #12 had intact cognition. Review of a the current physician order dated 11/27/24 revealed Resident #12 was on contact isolation for MRSA (methicillin-resistant Staphylococcus aureus). Review of nursing progress notes dated 11/19/24 through 01/22/25 revealed Resident #12 had a MRSA infection to his right lower extremity. Observation on 01/21/25 at 9:05 A.M. revealed a sign posted outside Resident #12's room stating he was in contact precautions. Further review of the sign revealed providers and staff must don gloves and gown before entry. Observation on 01/21/25 at 9:15 A.M. revealed Certified Nursing Assistant (CNA) #604 entering Resident #12's room without donning PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/21/25 at 9:16 A.M. from the open doorway of Resident #12's room, revealed CNA #604 standing next to Resident #12 wearing disposable gloves. CNA #604 was not wearing a disposable gown. Concurrent interview with CNA #604 confirmed she was not wearing a disposable gown and planned to assist Resident #12 to the toilet. CNA #604 stated she only was required to wear a disposable gown if she planned to come into contact with his legs. Interview on 01/21/25 at 9:24 A.M. with Unit Manager (UM) #700 revealed she planned to assist CNA #604 with Resident #12's care and confirmed CNA #604 should be wearing a disposable gown and gloves while providing any care to Resident #12 because he was in contact isolation. Interview on 01/21/25 at 5:40 P.M. with the Infection Preventionist, Registered Nurse (RN) #718, confirmed staff entering a resident's room with droplet precautions should wear a gown, gloves, and an N95. Further interview confirmed staff should remove all PPE prior to exiting the room, perform hand hygiene, and don a new N95 mask upon exit from the room. Continued interview with RN #718 confirmed staff should wear a gown and gloves prior to entering a resident's room in contact precautions, regardless of the type of care to be provided. Additionally, RN #718 confirmed Resident #12 was in contact precautions. Review of the staff schedule dated 01/21/25 revealed CNA #604 and CNA #771 were assigned to the 300 and 400 halls. Review of the undated policy, Infection Control Guidelines for All Nursing Procedures, revealed staff should use alcohol-based hand rub before and after direct contact with residents. Review of the policy, COVID-19 - Identification and Management of Ill Residents, revised May 2023, revealed staff entering the room of a resident diagnosed with COVID-19 shall wear an N95 mask, a gown, and gloves. Review of the policy, PPE - Using N95 Face Masks, dated 11/29/21, revealed staff should use a mask only once and discard it.