STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365284	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Care Center	225 W Main Street Shelby, OH 44875

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 16453 Based on medical record review, review of a self-reported incident, staff interview, and policy review, the facility failed to ensure residents were free from improper physician restraints. This affected one (#85) of three residents reviewed for restraints. The facility census was 104. Findings include: Review of Resident #85's medical record revealed admission to the facility occurred on 01/05/24 with medical diagnosis including subdural hematoma, alcohol abuse, stroke, seizures, and dementia. Review of a self-reported incident (SRI) dated 03/09/24 at 11:44 A.M. identified Licensed Practical Nurse (LPN) #214 observed LPN #220 place Resident #85 in a Broda chair (a type of chair use to help positioning) at the nurses' station with a gait belt strapped around her waistline. The investigation identified LPN #214 called the Director of Nursing (DON) to report the concern. The report identified the DON told LPN #214 to send LPN #220 home, remove Resident #85 from the Broda chair, and take the gait belt off. Interview with LPN #214 was completed on 04/02/24 at 7:39 A.M. The interview confirmed she witnessed LPN #220 put Resident #85 in a Broda chair and secure her in the chair with a gait belt. The interview confirmed Resident #85 was not in the chair for more than 10 to 20 minutes and she called the DON because there was no physician orders for restraining Resident #85. Interview with State tested Nurse Aide (STNA) #225 occurred on 03/09/14 at 12:14 P.M. and confirmed she was working in the facility on 03/09/24 when the incident occurred with Resident #85. The interview confirmed LPN #220 told STNA #230 to take Resident #85 out in a Broda chair and strap her in the chair with a gait belt. STNA #225 was asked to get the type of gait belt that was used to strap the resident into the chair. STNA #225 obtained a belt that had a click closed secured latch. STNA #225 confirmed the gait belt was around Resident #85 waist and around the chair so the resident could not stand up. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #220 occurred on 04/02/24 at 2:28 P.M. and confirmed Resident #85 was crawling on the floor and she was concerned the resident was going to hurt herself. LPN #220 confirmed she told STNA #230 to put Resident #85 in a Broda chair and she had a gait belt, and confirmed she did not even think about the gait belt being a physical restraint. LPN #220 confirmed Resident #85 was in the Broda chair with the gait belt around her at the nurses' station so she could keep the resident safe. Review of the undated facility policy for physical restraints revealed the definition referred to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising. This deficiency represents non-compliance investigated under Master Complaint Number OH00151966.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 16453 Based on observation, staff interview, and policy review, the facility failed to maintain daily posted nurse staffing data as required. This had the potential to affect all 104 residents residing in the facility. The facility census was 104. Findings include: Observation of the front door of the facility on 04/02/24 at 1:15 P.M. revealed a message board with the daily posted nurse staffing data dated 04/01/24 and 04/02/24. During an interview with the Director of Nursing (DON) on 04/02/24 at 1:39 P.M. a request was made to review the last two weeks of the facility's daily nurse staffing posting. The DON confirmed the facility had been throwing away the daily posted nurse staffing data and not keeping them as required. Review of the facility policy titled, Nurse Staffing Information, identified the facility will post the daily staffing information for public viewing and maintain the data for a minimum of 18 months. This deficiency was an incidental finding related to allegations contained in Master Complaint Number OH00152382 and Complaint Number OH00151892.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on medical record review, resident and staff interview, and review of a facility policy, the facility failed to ensure medications were administered as ordered. This affected two (#14 and #110) of five residents reviewed for medications. The facility census was 104. Findings include: 1. Review of Resident #14's medical record revealed admission to the facility occurred on [DATE] with diagnoses including rheumatoid arthritis, diabetes, chronic pain, and chronic obstructive pulmonary disease. Review of a comprehensive assessment dated [DATE] revealed Resident #14 was assessed as completely alert and oriented. Review of Resident #14's medical record revealed a physician order for the immunosuppressive medication to treat arthritis Humira subcutaneous (SQ) every 14 days. Review of Resident #14's medication administration record (MAR) for [DATE] revealed Licensed Practical Nurse (LPN) #232 documented on the MAR that Resident #14 received his Humira injection on [DATE]. There was no other documentation of the medication being administered during the month. Interview with Resident #14 on [DATE] at 8:24 A.M. confirmed there was a nurse recently who came in to administer the Humira injection and was not able to figure out how to do it correctly, so she threw the medication in the trash. Resident #14 confirmed this occurred on [DATE] and stated he spoke with the Director of Nursing (DON) regarding the situation. Interview with the Director of Nursing (DON) on [DATE] at 10:46 A.M. confirmed LPN #232 did not provide Resident #14 his Humira injection on [DATE] and signed off the [DATE] MAR as if she administered it. The interview confirmed Resident #14 originally told the Social Services Director on [DATE] about what happened and the facility started an investigation. Interview with LPN #233 on [DATE] at 10:46 A.M. stated after identifying Resident #14 did not receive his Humira injection on [DATE] another nurse gave Resident #14 his injection on [DATE]. The interview confirmed there was no documented evidence Resident #14 received the injection on the [DATE] MAR or in the progress notes. 2. Review of Resident #110's medical record revealed admission to the facility occurred on [DATE]. Diagnoses included dementia, chronic kidney disease and anxiety. Review of Resident #110's nursing progress notes dated [DATE] revealed Resident #110 had a decline in condition and the family gave consent for a hospice consult. Review of a nursing progress notes for Resident #110 dated [DATE] at 4:30 P.M. revealed family was notified of the continued health decline and Resident #110 was to be admitted to hospice in the morning. (continued on next page)

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a nursing progress note dated [DATE] at 11:42 P.M. revealed Resident #110 was assessed with mottling to bilateral feet and uneven increased abdominal respirations. Further review of nursing progress notes from [DATE] revealed Resident #110 was moaning and appear uncomfortable. The nurse called the physician who ordered the narcotic pain medication morphine and/or the antianxiety medication Ativan for comfort measures. Review of Resident #110's medication administration record (MAR) for [DATE] revealed the resident was ordered Morphine 20 milligrams per milliliter (mg/mL) to give 0.5 mLs by mouth every one hour as needed. The order had a start date of [DATE] at 12:19 A.M. and ended on [DATE] at 1:07 A.M. The same order was entered again with a start date of [DATE] at 1:33 A.M. and ended on [DATE] at 4:12 P.M. Further review of the [DATE] MAR revealed Resident #110 received no morphine during the month. Review of a nursing progress note dated [DATE] at 1:39 A.M. revealed the nurse was waiting on the pharmacy to call back with authorization to pull morphine for Resident #110. The resident appeared more comfortable and relaxed. Further review revealed Resident #110 expired on [DATE] at 1:55 A.M. Review of a nursing progress note dated [DATE] at 5:14 A.M. revealed the pharmacist called the facility that morning in regards to Resident #110's morphine order. The note identified the nurse informed the pharmacist Resident #110 had expired and had waited for over an hour, and would be placed on a call back list to receive authorization to pull the morphine from the facility's stock items. Further review of the note revealed the pharmacist apologized and indicated it had been a long night and they had technical issues that night and just was able to call the facility back. Interview with Cooperate Registered Nurse #231 on [DATE] at 2:14 P.M. verified Resident #110 did not received morphine as ordered when it was needed due to signs of discomfort. Review of a facility policy titled, Medication Administration, dated 2013, revealed it was the policy of the facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Medications should be administered only as prescribed by the provider. This deficiency represents non-compliance investigated under Complaint Number OH00151892.

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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** 16453 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were stored in a safe and proper manner. This affected one (#17) of five residents reviewed for medications. The facility census was 104. Findings include: Review of Resident #17's medical record revealed the resident was admitted to the facility on [DATE] with medical diagnoses including subdural hemorrhage, kidney failure, and convulsions. Review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with severe cognitive impairment. Observation on 04/02/24 at 9:31 A.M. in Resident #17's room revealed there was a cup full of medications sitting on the bedside stand. Continued observation revealed Licensed Practical Nurse (LPN) #213 was overheard telling Resident #17 she would leave the medications for him to take later, and LPN #213 was then observed to moving the medication cart down the hallway away from the resident's room. Interview with LPN #213 on 04/02/24 at 9:37 A.M. confirmed she left Resident #17's medications at the bedside and did not observe him take the medications. Review of the facility's undated medication administration policy revealed to remain with the resident until medication was swallowed and do not leave medication at the bedside. This deficiency was an incidental finding related to allegations contained in Master Complaint Number OH00152382.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on medical record review and resident and staff interviews, the facility failed to ensure medication administration was accurately documented in the medical record. This affected one (#14) of five residents reviewed for medications. The facility census was 104. Findings include: Review of Resident #14's medical record revealed admission to the facility occurred on 06/13/19 with diagnoses including rheumatoid arthritis, diabetes, chronic pain, and chronic obstructive pulmonary disease. Review of a comprehensive assessment dated [DATE] revealed Resident #14 was assessed as completely alert and oriented. Review of Resident #14's medical record revealed a physician order for the immunosuppressive medication to treat arthritis Humira subcutaneous (SQ) every 14 days. Review of Resident #14's medication administration record (MAR) for March 2024 revealed Licensed Practical Nurse (LPN) #232 documented on the MAR that Resident #14 received his Humira injection on 03/27/24. There was no other documentation of the medication being administered during the month. Interview with Resident #14 on 04/11/24 at 8:24 A.M. confirmed there was a nurse recently who came in to administer the Humira injection and was not able to figure out how to do it correctly, so she threw the medication in the trash. Resident #14 confirmed this occurred on 03/27/24 and stated he spoke with the Director of Nursing (DON) regarding the situation. Interview with the Director of Nursing (DON) on 04/11/24 at 10:46 A.M. confirmed LPN #232 did not provide Resident #14 his Humira injection on 03/27/24 and signed off the March 2024 MAR as if she administered it. The interview confirmed Resident #14 originally told the Social Services Director on 03/28/24 about what happened and the facility started an investigation. Interview with LPN #233 on 04/11/24 at 10:46 A.M. stated after identifying Resident #14 did not receive his Humira injection on 03/27/24 another nurse gave Resident #14 his injection on 03/30/24. The interview confirmed there was no documented evidence Resident #14 received the injection on the March 2024 MAR or in the progress notes. This deficiency was an incidental finding related to allegations contained in Complaint Number OH00151892.