Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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	05/22/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, interview, record review, policy review, and self reported incident (SRI) review, the facility failed to report, investigate and document allegations of resident-to-resident abuse. This affected six (Residents #100, #97, #98, #80, #83, and #101) of eight residents reviewed for abuse, neglect, and misappropriation of property. The facility census was 107. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE]. Medical diagnoses included frontal lobe and executive function deficit following cerebrovascular accident (CVA, stroke), depression, schizoaffective disorder, and insomnia. Review of Resident #100's Minimum Data Set (MDS) quarterly assessment, dated 02/20/24 revealed the resident had severely impaired cognition. Resident #100 was assessed as not having any hallucinations, delusions, behaviors, or rejection of care. Resident #100 required supervision with transfers and mobility, and was noted to require substantial/maximum assistance with dressing and was dependent on staff for showering, toileting hygiene, oral hygiene, donning and doffing footwear, and personal hygiene. Review of Resident #100's care plan, initiated on 07/27/21 and revised on 10/24/23, revealed the resident had a behavior problem at times due to impulsive behavior following a CVA. Resident #100 was noted to, at times, experience increased agitations, threaten violence, and to refuse care and medication at the time of increased agitation. The listed interventions included to administer medications as ordered, obtain behavioral health consults as needed, communicate with resident and the resident's representative regarding behaviors and treatment, and encouraging activity participation. The care plan referenced a medication review with psychiatric services completed on 10/24/23. Additional interventions included intervening as necessary to protect the rights and safety as others, notifying the medical provider of increased episodes of behaviors, and to attempt non-pharmacological interventions such as redirection, and the offering of food and drink. Review of the medical record for Resident #100 revealed the following resident-to-resident interactions with other residents: (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #100's progress notes revealed on 04/24/24 at 5:00 P.M., recorded by LPN #324, which stated Resident #100 lunged towards Resident #97 to hit him in the face on the right side. Two aides were present and de-escalated the situation, and it was unclear if Resident #100 made physical contact with Resident #97. The note identified Resident #97 was observed with a red area on his nose and chin following the interaction while Resident #100 was not injured. A clarification note dated 04/24/24 at 6:47 P.M., recorded as a late entry on 04/26/24, provided clarification that there was no physical contact, rather Resident #100 threw a cup of juice in Resident #97's face. Resident #100's interdisciplinary progress notes contained no follow-up notes to the incident. Review of Resident #97's progress notes revealed a note dated 04/24/24 at 5:22 P.M. indicating he was possibly struck by Resident #100. The note indicated there was a red area on his nose and chin of unknown etiology. Resident #97 was recorded as being assessed for injuries with none found. His vital signs were recorded as within normal limits. The note did not contain any indication of notification to Resident #97's family or to the provider. Resident #97's interdisciplinary progress notes contained no follow-up notes to the incident. Review of Resident #97's PRN (as-needed) Skin Check assessment, dated 04/24/24, revealed the resident had a new area of non-pressure observed. The assessment provided no description, location, or measurement of the new skin area. Review of the Ohio Department of Health (ODH) Certification and Licensure System (CALS) on 05/06/24 at 1:35 P.M. and again at 4:38 P.M. revealed no SRI had been filed related to the interaction between Resident #100 and Resident #97 on 04/24/24. During an interview on 05/06/24 at 2:37 P.M., the Administrator stated this situation should have been considered a resident-to-resident physical altercation. The Administrator confirmed this was not reported to the State Agency nor investigated timely. The Administrator additionally confirmed that the facility's policy calls for events to be documented in the resident's medical record. 2. Review of Resident #100's interdisciplinary progress notes revealed a note dated 04/26/24 at 11:58., recorded by RDCO #250, revealed on 04/25/24 Resident #100 was noted near Resident #98. Two State tested Nursing Assistants (STNA) were in the adjacent dining room and saw Resident #100 utilize his forearm in a reflex-type backward motion and push Resident #98 in his abdomen. The note stated there was no agitation or aggression. The note indicated residents were separated and increased supervision was implemented. The physician was updated and laboratory testing, including a complete blood count (CBC), urinalysis with culture and sensitivity, were ordered as STAT on 04/26/24. There was no documentation of the event recorded by any direct-care nursing staff on 04/25/24, the day of the alleged incident. Review of the ODH CALS website on 05/06/24 at 1:35 P.M. and 4:38 P.M., and again on revealed no SRI had been filed related to the interaction between Resident #100 and Resident #98 on or about 04/25/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/24 at 2:25 P.M., a family member of Resident #98 revealed she was phoned approximately two weeks ago by a nurse who reported Resident #98 was punched in the stomach by Resident #100. The family member stated they visited near daily, and Resident #98 had been fearful of being in his room, and frequently wanted to walk down the hall away from his room. The family member gestured across the hall and indicated Resident #100 lived directly across the hall from Resident #98. During an interview on 05/07/24 at 1:46 P.M., State tested Nursing Assistant #252 revealed she witnessed an altercation between Resident #100 and Resident #98 approximately two weeks ago. Resident #98 had been trying to stand up from the table in the dining room, when Resident #100 reached over and punched him in the stomach, unprovoked. During an interview on 05/07/24 at 3:10 P.M. with STNA #262 revealed she worked in the memory care unit on a regular basis and witnessed an altercation a few weeks ago where Resident #100 punched Resident #98 in the stomach. Review of the ODH CALS system on 05/13/24 at 2:08 P.M. revealed no SRI was filed by the facility related to the alleged event. An interview on 05/06/24 at 2:37 P.M. with the Administrator confirmed this altercation was not reported to the state agency. During an interview on 05/09/24 at 4:20 P.M., the Director of Nursing (DON) and Regional Director of Clinical Operations (RDCO) #250 verified this instance was not timely documented in the resident's medical record, nor was it documented by staff with firsthand knowledge of the event, nor interventions placed following the altercation. 3. Review of Resident #100's interdisciplinary progress notes revealed a note dated 04/28/24 at 10:05 P.M. authored by LPN #406, which stated at approximately 6:45 P.M. she heard Resident #100 yell out, stand from the recliner, look toward a female patient, and engage in a verbal altercation, using expletive language in telling the resident Shut the [expletive] up and I will [expletive] you up. Resident #100 stepped towards Resident #80, swinging his arms, with LPN #406 physically intervening between the two residents. The note recorded Resident #100 hit LPN #406 in her right forearm. Review of SRI #247221, filed on 05/06/24 for the event which occurred on 04/28/24, revealed an alleged occurrence of resident-to-resident verbal abuse between Resident #100 and Resident #80. The investigative file contained staff statements from STNA #358 and LPN #324. The witness statements contained in the investigative file were dated 04/29/24 for the event which occurred on 04/24/24. The staff statements were recorded by Corporate Nurse #330, typed and dated with no time recorded on the statements. The only staff signature on the forms were Corporate Nurse #330's. During an interview on 05/09/24 at 4:20 P.M. with the DON and RDCO #250 verified this instance was not timely reported to the state agency. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #100's interdisciplinary progress notes revealed a note dated 05/03/24 at 3:51 P.M., authored by Social Services Director (SSD) #300, referencing Resident #100 displaying negative verbal behaviors and agitation. The note indicating SSD #300 was seeking a referral for Resident #100 to receive psych services at an inpatient facility due to increased behaviors since last interaction with the resident. A subsequent note also authored by SSD #300 dated 05/04/24 at 9:33 A.M. referenced her having reached out to the inpatient psych facility, speaking with a nurse liaison who was not able to accept Resident #100 for admission as they require additional documentation such as nurses notes. The DON was informed of the conversation and need for additional documentation. The note referenced Resident #100 remained at the facility. Subsequent review of progress notes dated 05/03/24 and 05/04/24 revealed no nursing documentation of a resident interaction. As of 05/14/24, no note of the incident had been entered into Resident #100's record by direct care nursing staff. Review of Resident #83's interdisciplinary progress note revealed an interdisciplinary team note dated 05/08/24 summarizing the events of 05/03/24. The note stated Resident #83 was at the dining room table, seated across from another make resident who he began to converse with. An unnamed visitor reported a physical altercation, with another resident observed to place his hands on Resident #83's left arm. Staff responded and separated the residents, who were then assessed by nursing staff. The aggressor is not identified in the note. Subsequent progress notes, also dated 05/08/24 reflected Resident #83 had a verbal disagreement with another male resident, and the resident's son was notified of the 05/03/24 event on 05/06/24 at 2:30 P.M. The progress notes are silent to physician notification of the altercation. Review of SRI #247115, timely filed on 05/03/24 for the event which occurred on 05/03/24, revealed an alleged occurrence of resident-to-resident physical abuse between Resident #100 and Resident #83. The investigative file contained staff statements from STNA #262 and STNA #254. The witness statements contained in the investigative file were dated 05/03/24 and were observed to be modified with a different colored pen rephrasing aspects of the statement. STNA #252's original statement recalled Resident #83 take a swing at Resident #100's head and Resident #83 stating you're not going to hit me. The statement was rephrased to indicate Resident #83 only moved his arm towards Resident #100, with the word head crossed out. STNA #262's original statement reported seeing Resident #83 and Resident #100 face to face with both residents angry with each other and indicated she had only witnessed the tail end of it. The phrase face to face was rephrased to speaking to each other and the part about both residents being angry was crossed out. The handwritten staff statements were re-typed and recorded by the DON and signed by each staff member. During an interview on 05/07/24 at 3:10 P.M., STNA #262 revealed she did witness the tail end of the altercation between Resident #100 and Resident #83. Both residents were very angry, and Resident #83 had stated Resident #100 hit him. She recalled Resident #83 had a hand print on his arm and a new skin tear, but Resident #100 was uninjured. During an interview on 05/09/24 at 4:20 P.M., the DON and RDCO #250 verified this instance was not timely documented in the residents' medical record. 5. Review of both Resident #100 and Resident #101's interdisciplinary progress notes from 05/01/24 to 05/14/24 revealed no nursing documentation regarding a resident-to-resident altercation on 05/06/24 between the two residents. There was no description of the incident, any assessment of the residents following the incident, any intervention taken by staff, or care plan revisions implemented following the incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #101's progress notes revealed the only documentation of an alleged event on 05/06/24 occurring were psychosocial follow up notes dated 05/06/24 and 05/08/24 reflecting no adverse psychosocial events were suffered by Resident #101. Review of Resident #100's progress notes revealed no documentation regarding an alleged event on 05/06/24. A note dated 05/08/24 revealed Resident #100's emergency contact was notified of the incidents which occurred with Resident #100 on 05/03/24 and 05/06/24. As of 05/14/24, there was no documentation of any alleged resident-to-resident altercation. During an interview on 05/09/24 at 4:20 P.M., the DON and RDCO #250 verified this altercation was not timely documented in the medical record. Review of the policy titled OHIO Abuse, Neglect, & Misappropriation, undated, revealed in the event a situation is identified, an investigation by executive leadership will follow up. Statements will be obtained from staff related to the incident, including victim, person reporting the incident, accused perpetrator, and witnesses. This statement should be in writing, signed, and dated at the time it was written. Supervisors may write the statement for a person giving a statement about the incident to them and the person giving the statement must sign and date it, or a third party may witness the statements. The facility will take measures to protect residents from harm during an investigation. Allegations that does not result in serious bodily injury must be reported within 24 hours. In the event alleged abuse involves a resident-to-resident altercation, the residents will be placed in separate areas by staff, and appropriate physical assessments will be completed on each resident. The physician will be notified, the care plan updated, and the appropriate referrals made. Documentation of the facts and findings will be completed in each resident medical records. The physician and resident representative should be notified, and care plans should be updated. This deficiency is an example of continued non-compliance investigated under Complaint Number OH00153688 and continued non-compliance from the survey dated 03/04/24.

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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** 47990 Based on observation, staff and resident interview, record review and policy review, the facility failed to ensure timely and appropriate incontinence care was provided for a resident. This affected one (Resident #27) of three residents reviewed for activities of daily living. The facility census was 107. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE]. Medical diagnoses included mild dementia, chronic kidney disease, and muscle weakness. Review of Resident #27's incontinence care plan, dated 06/13/23, revealed he was incontinent of bowel and bladder. Interventions included to check the resident for incontinence, wash, rinse, and dry perineum, and change clothing after incontinence episodes. Resident #27's activities of daily living care plan, dated 06/05/24, revealed Resident #27 was dependent on staff for toileting hygiene. Review of the Minimum Data Set (MDS) annual assessment, dated 04/25/24, revealed Resident #27 had severely impaired cognition. Resident #27 was dependent for toileting and was always incontinent of bowel and bladder. During an observation on 05/14/24 at 9:50 A.M., Resident #27 was lying in bed. A pervasive odor of urine and fecal matter was strong in the room. Resident #27 was lying flat in the bed and was observed soaked with urine through his brief, pants, t-shirt, and draw sheet. The fitted sheet on Resident #27's bed had a large ring of urine which extended from Resident #27's ears, down to his knees. Resident #27 was shivering and stated he was cold. State tested Nursing Assistant (STNA) #322 stated she was not assigned to the room today, but came to provide incontinence care. STNA #322 stated STNA #326 was assigned to Resident #26's care. STNA #322 provided incontinence care using appropriate technique. During an interview on 05/14/24 at 9:58 A.M., STNA #326 verified she was assigned Resident #27's care today. She stated she was finishing a 16 hour shift and was scheduled from 05/13/24 at 6:00 P.M. through 05/14/24 at 10:00 A.M. and confirmed her shift was about to end. STNA #326 stated she last changed Resident #27 at 5:30 A.M., and confirmed she had not checked to see if he needed incontinence care between those times. STNA #326 verified she should have checked Resident #27 to see if he needed incontinence care at least every 2 hours. Review of the policy titled Routine Resident Care, undated, revealed residents are to be provided routine daily care which included toileting and providing for incontinence with dignity while maintaining skin integrity. This deficiency represents non-compliance investigated under Complaint Number OH00153274.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, record review, interview, and policy review, the facility failed to ensure physician-ordered treatments were applied as ordered. This affected two (Residents #45 and #50) of three residents reviewed for treatment administration. The facility census was 107. Findings include: 1. Review of the medical record for Resident #45 revealed an admitted [DATE]. Medical diagnoses included venous insufficiency, chronic pain, and muscle weakness. Review of Resident #45's physician's orders revealed an order dated 03/31/24 for Resident #45 to have compression wraps applied to both legs daily in the morning, remove at bedtime, for edema. Review of Resident #45's Treatment Administration Record (TAR) for April 2024 revealed the wraps were not applied on 04/01/24, 04/13/24, 04/15/24, 04/22/24, and 04/26/24. Review of Resident #45's interdisciplinary progress notes revealed no documentation the resident had refused leg wraps on the above specified dates. During an observation on 05/06/24 at 7:54 A.M., Resident #45 was lying in bed. Both legs were visibly swollen and were not wrapped. The compression wraps were on the dresser. Resident #45 stated she has difficulty getting staff to consistently wrap her legs in the morning as staff state they do not have time. She states her legs are sore and painful because they are so swollen. Resident #45 estimated that she gets her legs wrapped roughly three times weekly. During an interview on 05/06/24 at 11:20 A.M.,Social Services Director (SSD) #220 revealed she had received a call from a family member of Resident #45 on 04/22/24 that there had been ongoing concerns with Resident #45 getting her legs wrapped as ordered. SSD #220 stated she had shared the concern with nursing and believed it had been resolved. During an interview on 05/06/24 at 11:32 A.M., a family member of Resident #45 revealed frustration related to Resident #45 getting her bilateral lower extremities wrapped as ordered. It had gone so far that the family member had to phone or show up to the facility to insist on getting Resident #45's legs wrapped. The family member indicated that she had shared this concern with the local ombudsman and had emailed SSD #220. The family member shared it is still a struggle to get Resident #45's legs wrapped on a consistent basis. During an interview on 05/07/24 at 2:25 P.M. with Regional Director of Clinical Operations (RDCO) #250 verified the five dates the leg wraps were not documented as being applied. RDCO #250 stated treatments should be documented or noted as refused, but not blank. 2. Review of the medical record for Resident #50 revealed an admitted [DATE]. Medical diagnoses included morbid obesity, lymphedema, and type II diabetes mellitus. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #50's physician orders revealed an order dated 04/30/24 to cleanse both legs with Hibiclens, apply an antifungal cream then triad from toes to knees, cover with ABD (absorbent dressing), secure with rolled gauze and apply ACE (compression) wraps from toes to knees twice daily. Review of Resident #50's TAR for May 2024 the dressings were not documented as completed on 05/02/24 day shift, 05/06/24 night shift, 05/08/24 and 05/09/24 day shift, 05/10/24 and 05/12/24 night shift and 05/13/24 day shift. Two night shifts, 05/03/24 and 05/07/24, a nurses note was placed which stated gauze wrap was not available so the dressing change was not completed. There was no indication the provider had been notified. During an observation on 05/14/24 at 3:30 P.M., Resident #50 was seated in her motorized wheelchair. She had a blanket covering her lap and legs. She stated the wound care provider had been in to see her legs wounds, specifically her left lower leg wound, that day at 9:30 A.M., but the facility nursing staff failed to reapply the ordered treatment. Resident #50 stated she asked three separate nurses and was told they would get to her later. She stated it is an ongoing problem getting dressings completed and dressings are done on the nurse's time, if at all. Resident #50 stated she was embarrassed as she had gone around all day with no pants on, with only a blanket covering the lower half of her body. She stated she had to change out the blanket covering her lap four times already, as her legs are seeping so badly and soaking the blanket. During an interview on 05/14/24 at 3:36 P.M., RDCO #250 verified the resident's dressings were incomplete and the wound provider rounded earlier that morning. RDCO #250 also verified the TAR lacked documentation the dressings were completed as ordered. Review of the policy titled Wound Care, undated, identified residents will receive treatments as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00153274.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47990 Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) was on duty for eight consecutive hours each day, seven days a week. This had the potential to affect all residents residing in the facility. The facility census was 107. Findings include: Review of the daily staffing reports from 04/22/24 to 05/06/24 revealed the facility had no listed RN coverage for Saturday 04/27/24 and Saturday 05/04/24. An interview on 05/15/24 at 10:25 A.M. with Regional Director of Clinical Operations (RDCO) #250 verified the Director of Nursing was not working in the building on Saturday 04/27/24 or 05/04/24, nor was there any evidence any other RN worked on those two dates. RDCO #250 verified the facility should have an RN on duty every day, at least 8 hours a day. This deficiency represents non-compliance investigated under Complaint Number OH00153688.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on staff interview, record review, and policy review, the facility failed to ensure physician-ordered laboratory testing was completed timely. This affected one (Resident #100) of three residents reviewed for laboratory testing. The facility census was 107. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE]. Medical diagnoses included frontal lobe and executive function deficit following cerebrovascular accident (CVA, stroke), depression, schizoaffective disorder, and insomnia. Resident #100 was discharged from the facility on 05/09/24. Review of Resident #100's care plan, revised on 02/22/24, revealed the resident used mood stabilizing medication related to schizoaffective disorder. Interventions included to monitor for side effects of medications, provide mood-stabilizing medications per medical provider's orders and provide psych consult and counseling services as needed. Review of Resident #100's physician's orders revealed an order dated 09/11/23 for Depakote 250 mg once daily in the morning, and 500 mg once daily in the afternoon for schizoaffective disorder. Review of Resident #100's psychiatric progress note, dated 02/12/24, revealed the Psychiatric Nurse Practitioner (Psych NP) #604 gave an order for a valproic acid level to be drawn and results reported to the facility provider and the psychiatric provider. Review of Resident #100's electronic and physical medical record revealed no evidence this order was ever transcribed or blood drawn for the test. During an interview on 05/09/24 at 11:25 A.M., the Director of Nursing (DON), Regional Director of Clinical Operations (RDCO) #250, and Corporate Nurse #330 verified the valproic acid level was never transcribed nor completed for Resident #100. A follow up interview at 05/09/24 at 1:21 P.M. with RDCO #250 revealed Resident #100 had other laboratory testing completed on 05/08/24. The facility was able to contact the lab provider who could run a valproic acid level on the specimen drawn 05/08/24. The facility's medical director gave the stat order for the valproic acid level to be completed. Review of Resident #100's interdisciplinary progress notes revealed the resident was experienced aggression towards other residents on 04/24/24 and 04/25/24. A follow up note on 04/26/24 at 12:47 P.M. revealed as a result of the alleged incident on 04/24/24, the physician ordered STAT (immediate) laboratory testing of a complete blood count (CBC), basic metabolic panel (BMP) and a urinalysis with culture and sensitivity testing (to check for a urinary tract infection). Subsequent review of the progress notes the laboratory blood testing was completed on 04/26/24, but there was no evidence of the urinalysis completed until 05/04/24, nor was there documented notification to the provider that the urine was unable to be completed. (continued on next page)

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

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/08/24 at 5:22 P.M. with RDCO #250 verified the urine specimen was not timely obtained for Resident #100. RDCO #250 stated the expectation would be if the specimen was unable to be provider, the physician would be notified. Review of the policy Principles of Specimen Collection, undated, revealed specimen collection is performed with an order from a physician or provider. The policy additionally stated to contact the unit supervisor or designee for questions or concerns regarding the specimen collection procedure. This deficiency represents an incidental finding during the investigation of Complaint Number OH00153688.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47990 Based on record review, staff and resident interview, policy review, and self-reported incidents (SRI) review, the facility failed to maintain accurate resident records. This affected four (Residents #84, #98, #101 and #100) of eight residents reviewed for accuracy of medical records. The facility census was 107. Findings include: 1. Review of the medical record for Resident #84 revealed an admitted [DATE]. Medical diagnoses included dementia without behavioral disturbance, anxiety, and schizophrenia. Resident #84 resided on the secured memory care unit. Review of Resident #84's interdisciplinary progress notes revealed a note dated 05/08/24 by Social Services Director (SSD) #300. The note referenced SSD #300 speaking to Resident #84 following an incident that occurred. The note revealed Resident #84 had no recollection of the event and no adverse psychosocial effects. Review of Resident #84's Treatment Administration Record (TAR), dated May 2024, revealed target behaviors staff was monitoring for included anxiety, refusing care, and refusing medications. Resident #84 was not recorded as having any behaviors in May 2024. 2. Review of Resident #98's medical record revealed an admitted [DATE]. Medical diagnoses included severe dementia with agitation, panic disorder, depression, and insomnia. Resident #98 was a resident of the secured memory care unit. Review of Resident #98's care plan, dated 03/06/24, revealed Resident #98 had a behavior problem related to dementia and had verbal and physical behaviors towards staff. Interventions included to approach and speak to the resident in a calm manner, obtain behavioral health consult as needed, encourage to participate in activities, monitor behavioral episodes and attempt to determine the underlying cause and notify medical provider of increased episodes of behaviors. Review of Resident #98's TAR revealed no behavior monitoring was located on the resident's MAR or TAR for April 2024 or May 2024. Review of Resident #98's interdisciplinary progress notes revealed a note dated 05/10/24 at 1:04 P.M. authored by the Director of Nursing (DON), which referenced her receiving a call on 05/05/24 involving a resident-to-resident occurrence on the secured memory care unit involving Resident #98. The note referenced Resident #98 was providing increased supervision, redirected, and provided with diversional activities. A subsequent note dated 05/10/24 at 1:30 P.M., also by the DON, revealed Licensed Practical Nurse (LPN) #338 notified Medical Director (MD) #750 and Resident #98's family member on 05/05/24 at 10:30 P.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Ohio Department of Health's (ODH) Certification and Licensure System (CALS) revealed a SRI, dated 05/05/24, revealed Resident #98 wandered into Resident #84's room and began a verbal interaction. Resident #98 was then observed to place his bilateral hands around Resident #84's neck. Staff intervened and separated the residents. The SRI was unsubstantiated due to both residents having cognitive impairments. During an interview on 05/08/24 at 4:05 P.M., LPN #338 stated she was the nurse on duty for the 05/05/24 incident. She walked into Resident #84's room, observed Resident #98 grasping, with both hands, Resident #84's throat. LPN #338 stated the two residents were separated. LPN #338 stated she was told by the DON via text message to notify the provider and the family, but not to give details of the incident, just a statement that there was a male to male physical interaction on the memory care unit would be sufficient. LPN #338 stated she was told by the DON that the DON would take care of documenting the event, but she felt uncomfortable because she noticed there was no entry in either of the two resident's records of the event. During an interview on 05/08/24 at 12:10 P.M., SSD #300 verified she was not aware of an altercation between Resident #84 and Resident #98 on 05/05/24. SSD #300 stated nothing was discussed in morning meeting or clinical meeting for the last three mornings and no one had told her. SSD #300 checked both Resident #84 and Resident #98's interdisciplinary progress notes and records and verified there was no documentation of the alleged event recorded in either resident's medical records. During an interview on 05/09/24 at 7:58 A.M., State tested Nursing Assistant (STNA) #394 stated they were a witness to the altercation on 05/05/24 between Resident #84 and Resident #98. STNA #394 stated the staff on 05/05/24 was told by the DON to not document anything in the medical record. STNA #394 stated they wrote a statement but was unsure what became of it. STNA #394 stated he had previously been told by both the DON and a (unnamed) nurse that if there was one more resident-to-resident interaction state will be back in. 3. Review of Resident #101's medical record revealed an admitted [DATE]. Medical diagnoses included moderate dementia with behavioral disturbance, bipolar disorder, anxiety, muscle weakness, and obsessive-compulsive disorder. Resident #101 was a resident of the secured memory care unit. Review of Resident #101's care plan, initiated on 03/28/24 and revised on 04/28/24, revealed Resident #101 had a behavior problem with behaviors that included moving the nursing cart, trying to steal food, disrobing, and aggressive with other residents. Interventions included to approach and speak in a calm manor, communicate with the resident and representative regarding behaviors and treatment, and notifying the medical director of increased episodes of behaviors. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #101's interdisciplinary progress notes revealed a note dated 05/06/24 at 1:37 P.M. authored by SSD #300. The note referenced SSD #300 discussing a situation that happened the morning of 05/06/24 with Resident #100. Resident #101 recalled Resident #100 got her in the head and pulled her hair. The note referenced Resident #100 reported she was fearful of Resident #100 and SSD #300 provided emotional support. Subsequent notes authored by SSD #300 on 05/07/24 at 12:20 P.M. and 05/10/24 at 12:12 P.M. provided psychosocial follow up with no adverse psychosocial effects. Additional review of Resident #101's progress notes from 04/14/24 to 05/14/24 revealed no description of the alleged incident on 05/06/24, no intervention taken, no assessment completed by nursing. The only mention of an incident occurring on 05/06/24 was a note dated 05/08/24 at 11:52 A.M. authored by LPN Unit Manager (UM) #410 stating Resident #101's sister was notified on 05/06/24 at 2:38 P.M. of an incident that occurred on the morning of 05/06/24. Review of Resident #101's TAR revealed no behavior monitoring was located on the resident's MAR or TAR for April 2024 or May 2024. 4. Review of Resident #100's medical record revealed an admitted [DATE]. Medical diagnoses included frontal lobe and executive function deficit following cerebral infarction (stroke), depression, schizoaffective disorder, insomnia, and a history of psychoactive substance abuse (in remission). Review of Resident #100's care plan, initiated 07/27/21 and revised on 10/24/23, revealed Resident #100 had a behavior problem at times. He was recorded as having impulsive behaviors, wandered into other residents' rooms, may take other residents' belongings. Resident #100 may experience increased agitation, or threaten violence, refuse care, and refuse medications at times of increased agitation. Care planned interventions included behavioral health consults as needed, communicate with resident/resident representative regarding behavior and treatment, intervene as necessary to protect the rights and safety of others, and implement nonpharmacological interventions of redirection and offering food and drink. The plan of care stated to notify the medical provider of increased episodes of behaviors. Review of Resident #100's progress notes from 05/01/24 to 05/14/24 revealed a note authored by SSD #300, dated 05/06/24 at 1:31 P.M., indicating that Resident #100 had been involved in an incident earlier that day with Resident #101. Resident #100 declined to talk to SSD #300 about the incident. Subsequent social service progress notes indicating the facility was seeking alternate placement were recorded by SSD #300. There was no nursing documentation of any alleged event or interaction between Resident #100 and Resident #101 during the above time frame. Review of the ODH CALS system revealed SRI #247217 was filed as an allegation of resident-to-resident physical abuse on 05/06/24. Resident #100 was observed by facility staff to place his hand on Resident #101's head and began tugging on Resident #101's hair. The report indicated the residents were separated and assessed. During an interview on 05/06/24 at 12:08 P.M., STNA #258 revealed there was a resident-to-resident interaction on the memory care unit. STNA #258 stated the DON asked staff to keep this situation quiet while a state surveyor was in the building and to delay documenting the incident until after the state surveyor had left. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/24 at 12:25 P.M., LPN #316 confirmed she witnessed an incident at approximately 8:00 A.M. where Resident #100 grasped a handful of Resident #101's hair and forcefully lifted her in an upright motion, with Resident #101's buttocks lifted a few inches off the seat of the chair. Resident #100 then dropped Resident #101 back down onto the seat of the chair after LPN #316 ran to separate the two residents. LPN #316 stated she had not documented the situation in either resident's medical records as the DON instructed her to not document, the DON would complete the documentation in each resident's medical record. During an interview on 05/09/24 at 4:20 P.M., the DON verified the lack of documentation in Resident #84, Resident #98, Resident #101, and Resident #100's medical records. The DON denied instructing staff to not document, rather had prior concerns with what and how staff were documenting and requested they review their charting with her prior to documenting in the medical record. The DON was unsure why resident interactions were still not documented in the medical record but stated there should be an entry in each record. Review of the policy titled OHIO Abuse, Neglect, & Misappropriation, undated, revealed in the event a situation is identified, an investigation by executive leadership will follow up. In the event alleged abuse involves a resident-to-resident altercation, the residents will be placed in separate areas by staff, and appropriate physical assessments will be completed on each resident. Documentation of the facts and findings will be completed in each resident medical records. The physician and resident representative should be notified, and care plans should be updated. This deficiency is an example of continued non-compliance investigated under Complaint Number OH00153688 and continued non-compliance from the survey dated 04/11/24.