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	09/25/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on medical record review, resident and staff interviews and policy review, the facility failed to timely inform and allow the resident to participate in their treatment. This affected one (#100) of three residents reviewed participation of their treatment/care. The facility census was 91. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE]. Diagnoses included osteoarthritis and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 had intact cognition. Resident #100 had pain occasionally in the last five days of the assessment reference period to which she received pain medication scheduled and as needed and did not receive non-medication interventions for pain. Review of Resident #100's August 2024 physician orders revealed an order for Oxycodone HCL (pain medication) oral tablet 10 milligrams (mg) administer one tablet by mouth two times a day for pain with a start date of 06/23/24. Oxycodone HCL was discontinued on 08/20/24. There was no documentation in the medical record Resident #100 was notified the Oxycodone was discontinued until four days later 08/24/24. Review of Resident #100's Medication Administration Record (MAR) for August 2024 revealed from 08/21/24 to 08/27/24, Resident #100 had pain levels ranging from six to 10 (pain scale from zero indicating no pain and ten being worse pain ever). Review of the nursing progress notes dated 08/24/24 at 3:09 P.M. revealed Resident #100 spent most of the shift in tears, unable to rest due to complaints of pain. Resident #100 stated Percocet was not effective for her pain but will take it due to not having anything else for pain. Review of the medication administration progress note dated 08/24/24 at 3:48 P.M. revealed Resident #100 had complaining of general pain rating it 10 out of 10 and stated Percocet was not effective. The progress was not silent for documentation of alternative pain solutions provided. (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: 365284	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024

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Crestwood Care Center	225 W Main Street Shelby, OH 44875

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing progress note dated 08/25/24 at 9:50 A.M. revealed Resident #100 was lying in bed crying and hands trembling. Resident #100 stated she was having so much pain she could not get comfortable and unable to sleep most of the night. Resident #100 stated she reached out to her son due to not being able to have her Oxycodone, and she stated again the Percocet was not effective. Residents' son did reach out to this nurse asking why the facility has not administered his mother her pain medication. The nurse instructed the son to call the facility and reach out to social services, as she may have some ideas that would be helpful. The medication administration progress note dated 08/25/24 at 4:40 P.M. documented Resident #100 rated her pain five out of ten and stated the Percocet was not effective. The progress note was silent for documentation of alternative pain solutions provided. Review of the social services progress notes dated 08/26/24 at 11:01 A.M. revealed Resident #100's son contacted the social services director (SSD) regarding medication changes. The son requested the Oxycodone medication to be re-instated. The Director of Nursing (DON) and the Administrator were made aware. The DON to contact the physician and follow up with the son. The nursing progress note dated 08/26/24 at 11:48 A.M. revealed Resident #100 was sitting up in her wheelchair watching television and she became tearful. Resident #100 was very tearful stating she just needed her pain medication (Oxycodone) back to make her feel better. The nurse reminded the resident that her son had called into facility and then she was less tearful at that time. The nursing progress note dated 08/26/24 at 12:54 P.M. revealed the nurse contacted Physician #1 regarding resident's complaint of uncontrolled pain. Resident was previously ordered Oxycodone HCL 10 mg twice a day; however, the medication was discontinued on 08/20/24 due to the Pharmacy and Therapeutics (P&T) meeting (a meeting to discuss the resident's medications and usage). Resident/family concerned the current order was not controlling pain. Physician #1 informed this nurse to request NP #3 to discontinue Oxycodone-acetaminophen as needed and restart routine Oxycodone. Interview on 09/25/24 at 8:30 A.M. with Resident #100 stated her pain was out of control when the facility physician stopped her Oxycodone 10 mg without her knowledge or family's knowledge for a week in August 2024. She started to feel ill with aching, nausea, shaking and increased pain in her legs and back to which she discussed with Licensed Practical Nurse (LPN) #3. Resident #100 stated LPN #3 suggested she was going through withdrawal because of the Oxycodone 10 mg being discontinued few days before. Resident #100 stated she was never informed of the medication being discontinued nor that she had been given Percocet 5/325 mg instead of the Oxycodone 10 mg (that she had taken for years that controlled her chronic pain). Resident #100 stated she requested to speak to her physician and to call and explain the severity of the pain she was experiencing. Resident #100 stated the nurses said they called the physician on multiple occasions and was unwilling to provide additional medications or any alternative treatments or intervention. Resident #100 stated for four to five days she suffered, she had the shakes, anxiety, excruciating pain in back, legs and feet that was not controlled by the Percocet, Tylenol, or distractive activity. Resident #100 stated she finally called her son for help after being advised by nursing home staff, because of the unwillingness of the physician to provide relief. Only after her son called, her medication was restored, and she began to have pain relief. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 on 09/25/24 at 9:20 A.M. stated Physician #1 was called by her and other nurses on multiple occasions notifying him of the severity of Resident #100's pain, with withdrawal symptoms when the Oxycodone was discontinued. LPN #3 verified Physician #1 refused to provide any alternative to help control Resident #100's pain until Resident #100's son got involved. LPN #3 stated she had never known Resident #100 to attempt to abuse narcotics, ask for more than prescribed, appear to be under the influence nor a medication seeker which was concerning because all the residents have the potential to have pain and even when a physician was presented with the nurses' assessment of a resident's pain, the physician was not prescribing any interventions. Interview with SSD #10 on 09/25/24 at 11:20 A.M. verified Resident #100 did express to her the distrust Resident #100 had regarding Physician #1 after his refusal to address her pain, refusal to talk with her and that no alternative physician had been discussed. SSD #10 verified Resident #100 could make her own health decisions, was not cognitively impaired, and should be informed of all medical decisions. Interview with the DON on 09/25/24 at 12:30 P.M. stated Resident #100's Oxycodone 10 mg was discontinued on 08/20/24 during a facility group meeting with Physician #1. The DON verified Resident #100, nor her family were in attendance during this facility meeting and was unable to provide documentation regarding notification of Resident #100 being notified of Oxycodone 10 mg being discontinued on 08/20/24. Attempts to interview Physician #1, NP #2 and NP #3 during the survey were unsuccessful. Review of the facility policy titled Pain Management and Assessments dated 04/16/24 revealed the facility must ensure the residents receive the treatment and care in accordance with professional standard of practice, the comprehensive care plan and the resident's choices related to pain management. Review of the facility policy titled Notification of Change in Condition dated 04/11/24 revealed the center must inform the resident and or resident representative when there is a change requiring such notification including circumstances that require a need to alter treatment which may include discontinuation of current treatment. This deficiency represents non-compliance investigated under Complaint Number OH00157343.

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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 0697

Level of Harm - Actual harm

Residents Affected - Few

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47988

Based on medical record review, resident and staff interviews, and policy review, the facility failed to provide effective pain control relief to a resident. This resulted in Actual Harm to Resident #100 when her physician discontinued the use of a narcotic pain medication (Oxycodone) without notifying the resident resulting in Resident #100 experiencing withdrawal symptoms including nausea and trembling hands and Resident #100 experiencing severe pain. This affected one (Resident #100) of three residents reviewed for pain management. The facility census was 91.

Findings include:

Review of the medical record for Resident #100 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type two with diabetic neuropathy, osteoarthritis, and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 had intact cognition. Resident #100 had pain occasionally in the last five days of the assessment reference period to which she received pain medication scheduled and as needed and did not receive non-medication interventions for pain.

Review of Resident #100's plan of care with revision date of 04/01/24 revealed the resident had complaints of pain related to osteoarthritis and chronic pain syndrome. Interventions included observation for pain every shift and administering non-pharmacological interventions. The goal for Resident #100 was to be able to verbalize relief of pain.

Review of Nurse Practitioner (NP) #03's note dated 08/20/24 revealed Resident #100's chief complaint was swelling and erythema to right lower leg. Resident #100 found lying supine in bed in no obvious discomfort. Resident #100 denied increased pain.

Review of Resident #100's August 2024 physician orders revealed an order for Percocet oral tablet 5/325 milligrams (mg) (pain medication) administer one tablet by mouth every eight hours as needed for moderate to severe pain. An order for Acetaminophen tablet 325 mg administer two tablets by mouth every six hours as needed for mild to moderate pain, not to exceed three grams acetaminophen in 24 hours started on 06/11/24. An order for Oxycodone HCL (pain medication) oral tablet 10 milligrams (mg) administer one tablet by mouth two times a day for pain with a start date of 06/23/24. Oxycodone HCL was discontinued on 08/20/24. There was no documentation in the medical record Resident #100 was notified the Oxycodone was discontinued until four days later on 08/24/24.

Review of Resident #100's Medication Administration Record (MAR) for August 2024 revealed from 08/20/24 to 08/27/24, Resident #100 received as needed Percocet 5/325 mg on 08/20/24 at 10:09 P.M. for a pain level of seven (pain scale from zero indicating no pain and ten being worse pain ever); on 08/21/24 at 7:08 A. M. for a pain level at seven; at 9:30 P.M. for a pain level of six; on 08/23/24 at 7:04 A.M. for a pain level of seven; on 08/24/24 at 7:38 A.M. for a pain level 10; on 08/24/24 at 3:45 P.M. for a pain level of 10; on 08/24/24 at 11:50 P.M. for a pain level of eight; on 08/25/24 at 9:50 A.M. for a pain level of 10; on 08/25/24 at 8:50 P.M. for a pain level of seven; on 08/26/24 at 1:15 P.M. for a pain level of seven; and on 08/27/24 at 6:35 A.M. for a pain level of six. Resident #100 received Oxycodone 10 mg at 8:00 A.M. on 08/20/24 for pain level of zero.

(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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing progress notes dated 08/24/24 at 3:09 P.M. revealed Resident #100 spent most of the shift in tears, unable to rest due to complaints of pain. Resident #100 stated Percocet was not effective for her pain but will take it due to not having anything else for pain. Review of the medication administration progress note dated 08/24/24 at 3:48 P.M. revealed Resident #100 had been complaining of general pain rating it 10 out of 10 and stated Percocet was not effective. The progress note lacked evidence of any documentation of alternative pain solutions provided. The nursing progress note dated 08/25/24 at 9:50 A.M. revealed Resident #100 was lying in bed crying and hands trembling. Resident #100 stated she was having so much pain she could not get comfortable and was unable to sleep most of the night. Resident #100 stated she reached out to her son due to not being able to have her Oxycodone, and she stated again the Percocet was not effective. Residents' son did reach out to this nurse asking why the facility has not administered his mother her pain medication. The nurse instructed the son to call the facility and reach out to social services, as she may have some ideas that would be helpful. The medication administration progress note dated 08/25/24 at 4:40 P.M. documented Resident #100 rated her pain five out of ten and stated the Percocet was not effective. The progress note lacked evidence of documentation of alternative pain solutions provided. Review of the social services progress notes dated 08/26/24 at 11:01 A.M. revealed Resident #100's son contacted the social services director (SSD) regarding medication changes. The son requested the Oxycodone medication to be re-instated. The Director of Nursing (DON) and the Administrator were made aware. The DON to contact the physician and follow up with the son. The nursing progress note dated 08/26/24 at 11:48 A.M. revealed Resident #100 was sitting up in her wheelchair watching television and she became tearful. Resident #100 was very tearful stating she just needed her pain medication (Oxycodone) back to make her feel better. The nurse reminded the resident that her son had called into facility and then she was less tearful at that time. The nursing progress note dated 08/26/24 at 12:54 P.M. revealed the nurse contacted Physician #01 regarding resident's complaint of uncontrolled pain. Resident was previously ordered Oxycodone HCL 10 mg twice a day; however, the medication was discontinued on 08/20/24 due to the Pharmacy and Therapeutics (P&T) meeting (a meeting to discuss the resident's medications and usage). Resident/family concerned the current order was not controlling pain. Physician #01 informed this nurse to request NP #03 to discontinue Oxycodone-acetaminophen as needed and restart routine Oxycodone. Review of NP #02's note dated 08/26/24 revealed Resident #100's chief complaint was chronic pain. Resident #100 had a past medical history of chronic pain due to spinal fracture, after a fall, causing severe nerve pain. Resident #100 was currently receiving Neurontin 600 mg four times daily, Acetaminophen 650 mg four times daily as needed and was on Oxycodone 10 mg for approximately 25 to [AGE] years, after seeing multiple specialists. The dose was changed to Percocet five mg/325 mg which was not providing adequate pain control. Resident #100 reported she used to exercise to reduce her depression symptoms and was not able to perform her exercise therapy while experiencing increased pain. The plan was to increase Oxycodone to 10 mg to twice a day and continue PRN (as needed) Acetaminophen. Resident #100 to return to normal exercise therapy once pain was reduced to baseline. (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 0697 Level of Harm - Actual harm Residents Affected - Few	The social services progress notes dated 08/27/24 at 9:08 A.M. revealed Resident #100 shared she has not received her medication that was discussed yesterday. The physician order for Oxycodone HCL tablet every 12 hours abuse-deterrent 10 mg give one tablet by mouth every 12 hours for moderate to severe pain was started on 08/27/24. The MAR for 08/27/24 and 08/28/24 revealed Oxycodone HCL ER tablet every 12 hours abuse-deterrent 10 mg was documented on 08/27/24 at 9:00 A.M as a 9 which indicated the medication not provided, and there was no pain level or corresponding nursing note. On 08/27/24 at 8:00 P.M., the MAR indicated the medication was provided with a pain level seven and on 08/28/24 at 8:00 A.M., it was documented a 5 which indicted the medication on hold/see nursing note. However, there was no corresponding pain level or nursing note. Interview on 09/25/24 at 8:30 A.M. with Resident #100 stated her pain was out of control when the facility physician stopped her Oxycodone 10 mg without her knowledge or family's knowledge for a week in August 2024. She started to feel ill with aching, nausea, shaking and increased pain in her legs and back to which she discussed with Licensed Practical Nurse (LPN) #03. Resident #100 stated LPN #03 suggested she was going through withdrawal because of the Oxycodone 10 mg being discontinued a few days before. Resident #100 stated she was never informed of the medication being discontinued nor that she had been given Percocet 5/325 mg instead of the Oxycodone 10 mg (that she had taken for years that controlled her chronic pain). Resident #100 stated she requested to speak to her physician and to call and explain the severity of the pain she was experiencing. Resident #100 stated the nurses said they called the physician on multiple occasions and was unwilling to provide additional medications or any alternative treatments or intervention. Resident #100 stated for four to five days she suffered, she had the shakes, anxiety, excruciating pain in back, legs and feet that was not controlled by the Percocet, Tylenol, or distractive activity. Resident #100 stated she finally called her son for help after being advised by nursing home staff, because of the unwillingness of the physician to provide relief. Only after her son called, her medication was restored, and she began to have pain relief. Interview with LPN #03 on 09/25/24 at 9:20 A.M. verified the MAR with a 5 and 9 indicated the medication was not provided and verified Resident #100 did not receive Oxycodone on 08/27/24 at 9:00 A.M. and 08/28/24 at 8:00 A.M. Physician #01 was called by her and other nurses on multiple occasions notifying him of the severity of Resident #100's pain, with withdrawal symptoms when the Oxycodone was discontinued. LPN #03 verified Physician #01 refused to provide any alternative to help control Resident #100's pain until Resident #100's son got involved. LPN #03 stated she had never known Resident #100 to attempt to abuse narcotics, ask for more than prescribed, appear to be under the influence nor a medication seeker which was concerning because all the residents have the potential to have pain and even when a physician was presented with the nurses' assessment of a resident's pain, the physician was not prescribing any interventions. Interview with SSD #10 on 09/25/24 at 11:20 A.M. verified Resident #100 did express to her the distrust Resident #100 had regarding Physician #01 after his refusal to address her pain, refusal to talk with her and that no alternative physician had been discussed. SSD #10 verified Resident #100 could make her own health decisions, was not cognitively impaired, and should be informed of all medical decisions. (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 0697 Level of Harm - Actual harm Residents Affected - Few	Interview with the DON on 09/25/24 at 12:30 P.M. verified there was no documentation of alternative pain-relieving measures/non-pharmacological interventions provided to Resident #100 from 08/20/24 through 08/28/24. The DON verified Resident #100's plan of care was not updated reflecting any alternative measures to help with pain relief. The DON stated Resident #100's Oxycodone 10 mg was discontinued on 08/20/24 during a facility group meeting with Physician #01. The DON verified Resident #100, nor her family were in attendance during this facility meeting and was unable to provide documentation regarding notification of Resident #100 being notified of Oxycodone 10 mg being discontinued on 08/20/24. Attempts to interview Physician #01, NP #02 and NP #03 during the survey were unsuccessful. Review of the facility policy titled Pain Management and Assessments dated 04/16/24 revealed neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The facility must ensure the residents receive the treatment and care in accordance with professional standard of practice, the comprehensive care plan and the resident's choices related to pain management. There is no objective test that can measure pain, the clinician must accept the resident report of pain. This deficiency represents non-compliance investigated under Complaint Number OH00157343.

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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 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. 47988 Based on record review and staff 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 91. Findings include: Review of the daily staffing reports from 09/17/24 to 09/23/24 revealed the facility had no listed RN coverage for Saturday 09/21/24 and Sunday 09/22/24. An interview on 09/25/24 at 11:25 A.M. with the Director of Nursing (DON) verified she did not work in the building on 09/21/24 and 09/22/24 and verified there was not a RN on duty in the building on Saturday 09/21/24 and on Sunday 09/22/24. The DON verified the facility should have an RN on duty every day, at least eight hours a day. This deficiency represents non-compliance investigated under Complaint Number OH00157343.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on medical record review, staff interviews, and review of the facility policy, the facility failed to timely implement effective and individualized interventions to address a resident's behavioral health concerns. This affected one (Resident #200) of three residents reviewed for behavioral health services. The facility census was 91. Findings include: Review of the medical record for Resident #200 revealed an admitted [DATE]. Diagnoses included alcohol dependence with alcohol induced persisting dementia and blind. Resident #200 was discharged from the facility on 09/25/24. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #200 was unable to complete the interview a Brief Interview Mental Status (BIMS) score. He required substantial/maximal assistance from staff for toileting, personal hygiene, upper and lower body dressing. Resident #200 did not have rejection of care, no physical restraints, and did not exhibit physical, verbal or other behavior symptoms during the assessment reference period. Review of the consent forms revealed the Power of Attorney (POA) signed the consent form for Resident #200 to receive psych services. Review of Resident #200's plan of care dated 08/28/24 revealed the utilization of anti-anxiety medication related to adjustment issues with interventions including psych consult and counseling services as needed. The goal was for Resident #200 to have decreased episodes of anxiety. Resident #200 also had a behavioral problem of urinating on the floor, walking into people, demanding money from them, when residents say no or go away, he gets verbally mean and balling his fist up, grabs other residents walkers, their food or items off tables, and refuses care from staff and was physical with staff and threatens physical actions. Interventions were to encourage resident to express feelings, encourage to maintain as much independence and control/decision making as possible, intervene as necessary to protect the rights and safety of others, observe and anticipate needs: thirst, food, body positioning, pain and toileting needs, praise any indication of progress in behaviors, and monitor behavior episodes and attempt to determine underlying causes. Review of the nursing progress notes revealed the following behavioral notes: On 08/07/24 at 7:30 P.M., Resident #200's pants were soaked through and the nurse and aide tried to get him to the bathroom to get cleaned up and also tried to change his clothing and get him ready for bed. Resident #200 then got combative, swinging his blind cane (a device used by many people who are blind. It allows its user to scan their surroundings for obstacles or orientation marks.) at staff, told them to get out of his room. When the staff left, he closed the door and started destroying his room, taking drawers out, throwing them on the ground, and pulling the call lights out of the wall. Progress note was silent for notification of physician or responsible party notification of behavior. (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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/11/24 at 3:51 A.M., Resident #200 stood outside the nurse's station majority of the shift and refused to lay down at all this shift. While in his room, he urinated all over his bed and floor, then proceeded to stand by a female resident for a long while just not saying anything. On 08/12/24 at 12:19 A.M., Resident #200 stood in the dining room behind a female resident and urinated in the dining room floor then denied urinating in the floor. Resident #200 was carrying on conversations with people who were not there and no one around him and at some points, he tended to get agitated. On 08/12/24 at 5:37 P.M., Resident #200 was standing in the middle of the dining room walking into people and demanding money from them. When they said no or go away, he was getting verbally mean, and was balling his fist up. He did not make contact with anyone. Staff tried to get him to calm down, but he was balling his fist up to the aide and nurse. Resident #200's telehealth notification note dated 08/13/24 at 5:08 P.M. revealed the resident was exhibiting aggression, he was blind, and ambulating into other residents. He then becomes increasingly agitated with aggressive behavior; he threatens other resident. The plan was to order hydroxyzine (treats anxiety) 25 milligrams (mg) every six hours as needed. Resident #200's social services noted dated 08/14/24 at 10:09 A.M. revealed a referral was sent to Psych 360 due to behaviors and medication management assistance. There was no evidence Resident #200 was seen by Psych 360 while at the facility. Resident #200's acute encounter Nurse Practitioner (NP) noted dated 08/14/24 revealed Resident #200 was seen for reports of steady increased agitation. Resident #200 was legally blind, and it did not appear Resident #200 received services to aid him in his disability, such as safety precautions, clock method when eating, and how to use cane. He was often found wandering in the halls or dining area and has been found to get into verbal altercations with other residents because he of his disability. Resident #200 often urinated in the halls despite being offered toileting. Documentation also shows aggression with staff attempting to hit staff with his cane. On 08/16/24 at 3:33 A.M., Resident #200 continued to urinate on the floor randomly even after toileting. Resident #200 becomes verbally agitated with attempts to redirect. Resident #200 often stands very closely to other residents when in the dining area and was verbally aggressive to other residents when asked to move away to create space between himself and others. Resident #200 frequently feels around with hands sometimes grabbing other walkers or food off table causing others to become upset at him. On 08/16/24 at 1:05 P.M., Resident #200 was walking with the nurse and became upset. Resident #200 stated, I am going to kill someone today, it probably won't be you but I'm gonna kill someone. The Director of Nursing (DON) and Administrator were notified. On 08/16/24 at 1:15 P.M., there was notification to Physician #1 regarding Resident #200's homicidal ideations, with new order to transfer to hospital, 911 notified and report given and informed staff that resident carries a pen in his sock and refers to it as his shank. POA informed of transfer. On 08/16/24 at 5:31 P.M., Resident #200 returned from acute hospital stay. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365284	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER: Crestwood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/16/24, Resident #200 has an appointment on 09/11/24 at 10:15 A.M. with neurology. There was no evidence Resident #200 went to the neurology appointment on 09/11/24 or that it was rescheduled. On 08/25/24, Resident #200 was restless and tried to move furniture in dining room, pushing other residents in wheelchairs and attempting to rip items off wall. On 08/26/24, Resident #200 refused to wear a brief and was voiding in the dining room. A voicemail message left with the POA to call back to discuss referrals for behavioral health placement due to increased behaviors. POA returned call and behavioral health placement referral was made to one facility. On 08/28/24, social services noted Resident #200 continues to be anxious and agitated appearance and behaviors. On 08/29/24, Resident #200 was fidgeting and pacing with call light in room and was unable to be redirected. Later in the day, Resident #200 became upset with staff trying to provide incontinence care. Resident #200 also wandering into other resident's rooms with other residents becoming upset. Resident #200 removed the fire extinguisher from the glass door and refused to eat dinner. On 08/30/24, social services noted Behavioral Health Placement #1 would accept Resident #200 once his payor source is confirmed to be Medicaid and do not want to accept a pending Medicaid resident at this time. On 08/31/24, Resident #200 found in room covered in bowel movement and playing with it. On 09/02/24, Resident #200's bed had been flipped on its side, mattress and blankets on the floor, and two chairs stacked on top of each other. Resident #200 was standing in bathroom fidgeting with call light cords. On 09/05/24, NP noted Resident #200 was well controlled with as needed Ativan for increased behaviors. On 09/06/24/24, Resident #200 was getting upset due to thinking everyone was in his house and he was trying to protect his sisters. He grabbed a hold of another resident. They aide was able to redirect and keep other residents safe. However, he wouldn't calm down so Emergency Medical Services (EMS) were notified and sent him to the hospital. He returned a few hours later. On 09/07/24, Resident #200 had behaviors on and off throughout the day. He was agitated with staff when trying to change clothes or toilet him. Ativan was administered around 9:30 A.M., and he remained upset and was off and on swearing at staff. He was standing over top of other residents when they were attempting to eat. He urinated in the dining room area floor times with staff again attempting to take him to the bathroom. Another dose of Ativan was administered in the afternoon with positive effect. On 09/08/24, Resident #200 had behaviors in the morning. He was slightly agitated when toileting but did allow staff to clean him up and change his clothes. He said someone was telling him to be bad but he didn't want to listen. The second dose of Ativan for the day showed effectiveness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365284	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/16/24, Behavioral Health Facility #1 did not have any open beds at this time. Referrals sent to two other facilities. On 09/20/24, Behavioral Health Facility #2 accepted Resident #200 and transportation being set up. On 9/23/24, Resident #200 smeared feces all over himself, wall in room and curtain. On 09/24/24, Resident #200 was aggressive with behavior. Took a plate tray and would not give it back to staff. Ativan was administered and effective. On 09/25/24, Resident #200 was transferred to Behavioral Health Facility #2. Resident #200's medical record was silent for Resident #200 being seen by a neurologist per physician order. The medical record was silent for Resident #200 being seen by Psych 360 per physician order. Concurrent interviews on 09/24/24 with State tested Nursing Aides (STNA) #13 and #16 stated Resident #200 had episodes of violent behavior of hitting staff, throwing items, destroying his room by throwing chairs and bedding, grabbing other residents items and throwing or just refusing to give back items, and touching other residents by grabbing their clothing, wheelchairs or walkers causing safety concerns for other residents. Resident #200 would urinate in impropriate places, wipe feces on himself, walls of unit and curtains and would remove his penis from his pants and standing in dining room next to women improperly. They had reported to nursing staff, Director or Nursing (DON), and Administrator every time an incident occurred. Interview on 09/24/24 at 9:45 A.M with Registered Nurse (RN) #22 stated Resident #200 had severe behaviors that were left untreated and or the staff lacked the resources/interventions to help combat the behaviors of Resident #200. Resident #200 was not provided with the mental health services he required to help combat his behaviors. Interview with the DON on 09/25/24 at 3:00 P.M. verified Resident #200 had a physician order and consent to be seen by the unhouse psychiatric services (psych 360) but had never been seen or treated by a psychiatrist/psychologist. The DON verified Resident #200 did not attend the scheduled neurological appointment on 09/11/24. The DON verified Resident #200 had psychological needs/behaviors that were not being properly addressed by the house physician/NPO and needed to have psychologist/psychiatric to provide behavioral assessment and or medication needs to help with the psychological well-being of Resident #200. Review of the facility's undated policy titled Behavior Management General revealed the facility is to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnosis or who may present a danger to themselves or others. The safety of the resident and others is a high priority, assess for problematic or dangerous behaviors. This deficiency represents non-compliance investigated under Complaint Number OH00157343.