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	12/16/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on interviews, record reviews, and policy review, the facility failed to ensure resident's advance directives were readily available and communicated to the interdisciplinary team. This affected one (#100) of three residents reviewed for advance directives. The facility census was 86. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE]. Diagnosis included dementia and stated Do Not Resuscitate- Comfort Care (DNR-CC). Under the tab advance directive, it stated DNR-CC dated [DATE]. There was no DNR uploaded in Resident #100's medical record. Review of the plan of care dated [DATE] for advance directive for DNR-CC. Interventions included obtain copies of advanced directives from resident/resident representative to have on file, dated provider order for code status and obtain the state specific DNR form. Review of the physician orders for [DATE] revealed no order related to resident's code status. Code status for DNR-CC was discontinued on [DATE]. Review of the face sheet on the electronic charting revealed no advance directive. Review of the hard chart revealed Face sheet [DATE] revealed Resident #100 was a DNR-CC and was current and verified on [DATE]. Review of the progress note dated [DATE] at 7:42 P.M. revealed Resident #100 had a change in condition. The nurse took vital signs, and they were critical, and squad was called. Resident #100 was unable to be resuscitated. Interview on [DATE] at 11:37 A.M. with Certified Nurse's Assistant (CNA) #301 stated she went to look for the DNR paper for Resident #100 and she was unable to find it. She took the chart to Licensed Practical Nurse (LPN) #390. LPN #390 looked in the chart also and was unable to find the signed DNR paper, but she did find on a hospital note that Resident #100 was a DNR. By the time the squad got to her, Resident #100 had passed away. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:51 P.M. with LPN #390 stated she was the nurse on when Resident #100 passed away. She did not start CPR because Resident #100 was a DNR-CC. She had CNA #301 go get the hard chart and she was unable to find the copy of the DNR, but she did find hospital paperwork that stated she was a DNR. LPN #390 stated she had no idea what her code status was only what she found in the chart and there was no face sheet in hard chart, and it was not on the orders. Interview on [DATE] at 3:40 P.M. with the Director of Nursing (DON) verified the advance directive paper should be accessible to all nursing staff and there should be a valid DNR in residents advance directive tab in the hard chart if a resident is a DNR. The DON stated the DNR paper was in the chart but the nursing staff was unable to find it. Review of the facility policy Advance Directive (Resident's Right to choose), dated [DATE] revealed upon admission, should the resident have an Advance directive, copies will be made and placed on the hard chart medical record as well as communicated to the staff. This deficiency represents non-compliance investigated under Complaint Number OH00159896.

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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 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** 36650 Based on resident and staff interviews, record review and observation, the facility failed to ensure Resident #78's continuity of care was reviewed and implemented timely. This affected one (#78) of three residents reviewed for medications. The facility census was 86. Findings include: Review of the medical record for Resident #78 revealed an admitted [DATE]. Diagnoses included heart disease, diabetes mellitus, and lymphedema. Review of the after-visit summary for obstetrics and gynecology dated 10/24/24 revealed a medication order changed for megestrol (hormone therapy) 40 milligrams (mg) two tablets twice a day to four tablets twice a day. Review of the Nurse Practitioner (NP) #300 dated 10/25/24 revealed Resident #78 reported she had a procedure in the gynecology office that left her really sore. Resident #78 stated she has had some relief with ibuprofen. Resident #78 has history of abnormal uterine bleeding and had a uterine scraping and was waiting to hear back if she needs a dilation and curettage (D&C) (a surgical procedure that involves dilating the cervix and using a spoon-shaped instrument to remove tissue from the uterus). Resident #78 stated she may just tell them to go ahead and perform a hysterectomy because she was tired of bleeding. Megestrol Acetate (hormone therapy) tablet 20 mg, give two tablets by mouth in the morning for postmenopausal bleeding and give two tablets by mouth in the evening for postmenopausal bleeding. On 11/11/24, the NP note revealed Resident #78 was waiting for referral to gynecology in at hospital to be seen for a hysterectomy. Resident #78 most recent hemoglobin/hematocrit (H/H) was low at 8.5/29.2 but was supposed to have been treated by gynecology. Resident #78 was not currently on an iron supplement and was agreeable to starting three times a day dosing regimen and have her blood work repeated. Significant anemia from blood loss could contribute to a tachy heart rhythm and lower blood pressure. Resident #78 otherwise reported she was sleeping well and reported her bowels and bladder were good as well as her appetite when she likes the food. She continues on Megestrol Acetate Tablet 20 mg, give two tablets by mouth in the morning for postmenopausal bleeding and give two tablets by mouth in the evening for postmenopausal bleeding Review of the progress note dated 11/13/24 at 3:29 P.M. revealed labs were drawn early morning and lab called to notify nurse that her hemoglobin was low 6.8. Resident #78 was sent to hospital for a transfusion due to Resident #78 was still bleeding from the vaginal area. Review of the physician orders and Medication Administration Record for November 2024 revealed Resident #78 was taking Megestrol 20 mg two tablets twice a day and was discontinued on 11/14/24. On 11/14/24, Megestrol 40 mg four tablets twice a day was started. Megestrol 40 mg four tablets twice a day was started 21 days after Resident #78's physician at obstetrics and gynecology appointment recommendation dated 10/24/24. (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 the NP #300 progress note dated 11/18/24 revealed Resident #78 received one unit of blood and returned to the facility with no new orders. Resident #78 was however, started on Ferrous Sulfate 325 mg by mouth three times a day just prior to her blood transfusion. Resident #78's gynecology was contacted to expedite her follow-up to discuss hysterectomy due to increased bleeding. Resident #78's Megestrol had also been doubled to 40 mg by mouth three times a day (at her last visit on 10/24/24) but was not started long prior to her transfusion. Resident #78's hemoglobin was rechecked that morning (11/18/24) and was 7.2 but was not available prior to her leaving for her three o'clock appt. Resident #78 reported she was still dizzy and was slightly hypotensive despite her Metoprolol being held for low blood pressure. Interview on 12/12/24 at 2:17 P.M. with Licensed Practical Nurses (LPN) #380 stated Resident #78 has been having bleeding concerns since the beginning of the year. Do not know when her order increased. LPN #380 stated order was changed on 10/14/24 she was looking at paperwork and saw the order had been changed and was not changed on her orders on 11/14/24 so she changed the order. The orders had been scanned into the computer and that was where she found the original order for the medication change. LPN #380 stated sometimes Resident #78 does not give her orders to the nurses when she comes back from appointments. LPN #380 stated the nurse on duty was to follow up with the physician if the paperwork was not brought back to the facility to see if there were any new orders. Interview on 12/12/24 at 3:40 P.M. with the Director of Nursing (DON) stated Resident #78 had an appointment on 10/24/24 with her gynecologist. The DON stated she was not sure if Resident #78 gave the nurse the paperwork when she returned to the facility. Resident #78 was seen by the NP #300 the next day and did not mention any medication change. NP #300 looked for notes from the appointment but was unable to find any. The Gynecologist did not sign the paperwork until 11/01/24 and this was when the notes were uploaded to Resident 78's medical record. The DON verified that if Resident #78 came back from an appointment without physician notes, the nurse on duty should have contacted the doctor to ensure there were no new orders. Interview on 12/16/24 at 9:18 A.M. with Registered Nurse (RN) #310 (surgeons office nurse) stated Resident #78 was referred to them for a hysterectomy. Resident #78 received a hysterectomy on 12/12/24. RN #310 stated she had been bleeding for 10 months and increase in the medications would not have kept her from having the hysterectomy, it was to help slow the bleeding down until she could have the hysterectomy. Interview on 12/16/24 at 9:28 A.M. with Resident #78 stated she had her hysterectomy on 12/12/24 and was doing well, a little sore. Resident #78 stated she could not remember if she had given the nurse the paperwork from the 10/24/24 appointment, which had the new order on it to increase the megestrol. Resident #78 stated it was in inevitable that she was going to have to have the hysterectomy, she had been bleeding for ten months. Attempted to reach the gynecologist about the ordered for megestrol during the survey was unsuccessful. This deficiency represents non-compliance investigated under Complaint Number OH00159899.