

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 03/25/2025
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)
<p>F 0620</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751</p> <p>Based on record review, admission agreement review, and interview the facility failed to ensure the consent to treat was signed timely. This affected one (#89) of three residents reviewed for consent to treat. The facility also failed to ensure admission agreements were signed timely. This affected one (#51) of three residents reviewed for admission agreements. The facility census was 86.</p> <p>Findings include:</p> <p>1. Review of medical record for Resident #89 revealed an admitted [DATE] and discharge date of [DATE] with diagnoses including but not limited to fracture of unspecified part of the neck of left femur, metabolic encephalopathy, nonrheumatic mitral valve insufficiency, chronic atrial fibrillation, dementia, rheumatic tricuspid valve insufficiency, and thrombocytopenia.</p> <p>Review of minimum data set (MDS) 3.0 assessment dated [DATE] revealed the resident was severely impaired with cognition and was rarely/never understood. Resident #89 was dependent for all activities of daily living.</p> <p>Review of nurses note dated 03/11/25 at 3:06 A.M. revealed resident arrived at 7:35 P.M. via emergency medical services (EMS). Family in not long after the resident arrived and at the bedside.</p> <p>Review of Care Conference Note dated 03/12/25 at 1:51 P.M. revealed the Power of Attorney daughter was in attendance.</p> <p>Review of PHP progress note dated 03/14/25 at 7:42 P.M. revealed the resident is comfort care. Oxygen level 84 percent on two liters. Death Rattle present per nurse. Per the nurse family is on their way to the facility. Atropine drops ordered.</p> <p>Review of nurses note dated 03/14/25 at 7:50 P.M. revealed the writer contacted the daughter about change in condition. Daughter stated she would be in as soon as possible.</p> <p>Review of nurses' note dated 03/14/25 at 11:40 P.M. revealed the resident was found absent of vital signs. Confirmed by two nurses. Family and physician notified.</p> <p>Review of the consent to treat revealed the form was signed on 03/14/25.</p> <p>(continued on next page)</p>

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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<p>F 0620</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/24/25 at 3:32 P.M. with the Director of Nursing (DON) verified that Resident #89's consent to treat was not signed until 03/14/25. DON verified the nursing staff were responsible for getting the consent to treat signed by the resident or their representatives upon admission.</p> <p>2. Review of medical record for Resident #51 revealed admitted [DATE] with diagnoses including but not limited to cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side, type two diabetes, metabolic encephalopathy, and nontraumatic intracerebral hemorrhage.</p> <p>Review of MDS dated [DATE] revealed the resident was cognitively intact.</p> <p>Review of consent to treat revealed the form was signed by the resident on 03/13/25.</p> <p>Review of the admission agreement revealed the resident signed on 03/24/25.</p> <p>Interview on 03/25/25 at 7:44 A.M. with Director of Public Relations (DPR #212) revealed the facility will typically get the admission agreements signed within three days of admission. DPR #212 verified she did not get Resident #51's paperwork signed until 03/24/25 which was 11 days after admission. DPR #212 stated when she met with the resident on 03/14/24 he did not feel up to doing paperwork. DPR #212 stated when she came back to the resident on Monday 03/17/25 he was in therapy. DPR #212 stated she is out of the building 90 percent of the time for marketing. DPR #212 verified she forgot that Resident #51 had not signed his paperwork.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00163843.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751</p> <p>Based on record review, interview, and facility policy review the facility failed to ensure wound treatment orders were obtained in a timely manner. This affected three (#11, #51, and #89) of three residents reviewed for wounds. The facility census was 86.</p> <p>Findings include:</p> <p>1. Review of medical record for Resident #11 revealed an admitted [DATE] with diagnoses including but not limited to peripheral vascular disease, type two diabetes, fracture of third and fourth lumbar vertebra, fracture of one rib, chronic obstructive pulmonary disease, malignant neoplasm of left bronchus, secondary malignant neoplasm of bone, and hypertension.</p> <p>Review of minimum data set (MDS) dated [DATE] revealed the resident was cognitively intact. Resident #11 had one stage three pressure ulcer present on admission and one unstageable pressure ulcer presenting as deep tissue injury present on admission.</p> <p>Review of Nursing Admission Evaluation dated 03/03/25 documented the following non pressure skin issues; right lower leg front scratch, and left lower leg dry thick patchy skin. Treatment order in place for each skin area are marked as not applicable.</p> <p>Review of current physician orders revealed there were no treatments or monitoring implemented for the non pressure skin wounds documented on the nursing admission evaluation.</p> <p>Review of Treatment Administration Record (TAR) for March 2025 confirmed no treatment or monitoring was implemented for the right lower leg or the left lower leg.</p> <p>2. Review of medical record for Resident #51 revealed admitted [DATE] with diagnoses including cerebral infarction, hemiparesis and hemiplegia following cerebral infarction affecting unspecified side, type two diabetes with foot ulcer, metabolic encephalopathy, nontraumatic intracerebral hemorrhage, and chronic kidney disease stage three.</p> <p>Review of MDS dated [DATE] not completed revealed the resident was cognitively intact.</p> <p>Review of Resident #51's Nursing Admission Evaluation dated 03/13/25 documented the following non pressure skin issues: left toes surgical incision measuring 6.0 cm by 0.1 cm by 0.0 with a treatment order in place.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the wound assessment completed by the wound NP dated 03/18/25 revealed the resident had the following wounds: Left great toe skin tear/laceration acquired not in house on 03/13/25, measured 0.4 cm by 4.20 cm by 0.1 cm, edges were documented as sutured and approximated well, there was scant serosanguineous exudate. Treatment was documented as cleanse with wound cleanser, cover with oil emulsion, pad with gauze and Kerlix, complete daily and as needed. Right great toe abrasion acquired not at the facility on 03/13/25, measured 0.6 cm by 0.6 cm by 0.1 cm the wound was 100% epithelial tissue with no drainage or exudate. Treatment was documented as cleanse with wound cleanser, apply betadine and leave open to air, complete twice daily. Right second toe abrasion acquired not at the facility on 03/13/25, documented as improving without complications and measured 0.7 cm by 1.2 cm by 0.0 cm. The wound was 100 % epithelial with no exudate or drainage. The treatment was documented as cleanse with wound cleanser apply betadine and leave open to air, complete twice daily.</p> <p>Review of current physician orders revealed left great toe cleanse with wound cleanser, apply oil emulsion to the base of the wound, pad with gauze and secure with Kerlix daily started 03/15/25, right great toe cleanse with wound cleanser, apply betadine to base of the wound twice daily and leave open to air started 03/15/25, and right second toe cleanse with wound cleanser, apply betadine to the base of the wound twice daily and leave open to air started 03/15/25.</p> <p>Review of TAR for March 2025 revealed treatments were started on 03/15/25 and not the day acquired 03/13/25.</p> <p>3. Review of medical record for Resident #89 revealed admitted [DATE] and discharge date of [DATE] with diagnoses including but not limited to fracture of unspecified part of the neck of left femur, metabolic encephalopathy, nonrheumatic mitral valve insufficiency, chronic atrial fibrillation, dementia, rheumatic tricuspid valve insufficiency, and thrombocytopenia.</p> <p>Review of MDS dated [DATE] revealed the resident was severely impaired with cognition and was rarely/never understood. Resident was dependent for all activities of daily living.</p> <p>Review of Nursing Admission Evaluation dated 03/10/25 documented the following non pressure skin issues; left arm skin tear, hematoma to right forehead, and red sacrum. Treatment order was marked as not applicable for all areas.</p> <p>Review of wound assessment completed by wound NP on 03/14/25 revealed the resident had the following skin wounds: Left buttock abrasion acquired not at the facility on 03/10/25, measured 6.5 cm by 1.5 cm by 0.1 cm documented as 100% epithelial with scant amount of serosanguineous exudate. Treatment was documented as cleanse with wound cleanser, apply oil emulsion and bordered foam, complete daily and as needed.</p> <p>Review of skin and wound note dated 03/14/25 at 8:23 P.M. revealed skin tear noted to left buttock present on admission with partial thickness measuring 6.5 cm by 1.5 cm by 0.1 cm and treatment ordered.</p> <p>Review of physician orders revealed an order dated 03/15/25 to cleanse left buttock with wound cleanser, apply oil emulsion to base of the wound and cover with bordered gauze daily. No treatment order to left buttock prior to 03/15/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/25/25 with the Director of Nursing (DON) verified the wound treatment orders for Residents (#11, #51, and #89) were not put into place when the wounds were identified and were not implemented timely. DON stated that the wound nurse was responsible for getting the orders for the wounds upon admission and she quit without notice. DON verified that this represented a delay in treatment.</p> <p>Review of policy titled Skin Care and Wound Management not dated revealed residents admitted with or develop skin integrity issues will receive treatment as indicated based on location, stage and drainage.</p> <p>This deficiency represents on going non-compliance from the survey dated 02/27/25 and represents non-compliance investigated under Complaint Number OH00163843.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751</p> <p>Based on record review, interview, and policy review the facility failed to ensure pressure ulcer wound treatment orders were obtained in a timely manner. This affected one (#11) of three residents reviewed for wounds. The facility census was 86.</p> <p>Findings include:</p> <p>Review of medical record for Resident #11 revealed an admitted [DATE] with diagnoses including but not limited to peripheral vascular disease, type two diabetes, fracture of third and fourth lumbar vertebra, fracture of one rib, chronic obstructive pulmonary disease, malignant neoplasm of left bronchus, secondary malignant neoplasm of bone, and hypertension.</p> <p>Review of minimum data set (MDS) dated [DATE] revealed the resident was cognitively intact. Resident #11 had one stage three pressure ulcer present on admission and one unstageable pressure ulcer presenting as deep tissue injury present on admission.</p> <p>Review of Nursing Admission Evaluation dated 03/03/25 revealed the following skin issues coccyx stage two pressure measuring 2.0 centimeters (cm) by 0.3 cm, right toes (unspecified) pressure ulcer with no stage or measurements provided, and right lateral foot pressure ulcer with no stage and no measurement provided. Treatment order in place for each skin area noted is marked as not applicable.</p> <p>Review of wound assessment completed by the nurse practitioner (NP) dated 03/18/25 revealed Resident #11 had a stage III pressure ulcer on the sacrum that was acquired on 03/04/25 and measured 1.8 cm by 0.4 cm by 0.6 cm. The wound was described as improving without complications with 20 percent (%) epithelial tissue, 80% granulation tissue with moderate serosanguineous drainage. The wound was to be cleansed with wound cleanser apply medical grade honey, calcium alginate, and cover with Border foam. Right great toe pressure ulcer deep tissue injury, acquired on 03/04/25 and measured 0.6 cm by 0.6 cm by 0.0 cm the wound was documented as improving without complications dark purple maroon non blanching. The treatment was cleanse with wound cleanser, treat with betadine and cover with a bordered gauze daily and as needed. No other pressure wounds were documented in the assessment.</p> <p>Review of current physician orders revealed treatment to right great toe to cleanse with wound cleanser, apply betadine to the base of the wound and cover with bordered gauze daily started on 03/07/25 and sacrum wound cleanse with wound cleanser, apply medical grade honey and calcium alginate to the base of the wound and cover with bordered foam daily started on 03/05/25.</p> <p>Review of discontinued medications revealed no treatment orders prior to 03/05/25.</p> <p>Review of Treatment Administration Record (TAR) for March 2025 revealed treatment to sacrum was not started until 03/08/25 and was not marked as completed on 03/14/25 and 03/21/25.</p> <p>Interview on 03/25/25 with the Director of Nursing (DON) verified the wound treatment orders for Residents #11 were not timely obtained and implemented. DON stated that the wound nurse was responsible for getting the orders for the wounds upon admission and she quit without notice. DON verified Resident #11 had a delay in treatment.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of policy titled Skin Care and Wound Management not dated revealed residents admitted with or develop skin integrity issues will receive treatment as indicated based on location, stage and drainage.</p> <p>This deficiency represents non-compliance investigated during Complaint Number OH00163843.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751</p> <p>Based on record review, review of the late administration medication report, interview, and facility policy review the facility failed to ensure medications were administered per physician order. This affected three (#11, #16, and #51) of seven residents reviewed for medications. The facility census was 86.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of medical record for Resident #11 revealed admitted [DATE]. Diagnoses included but not limited to peripheral vascular disease, type two diabetes, fracture of third and fourth lumbar vertebra, fracture of one rib, chronic obstructive pulmonary disease, malignant neoplasm of left bronchus, secondary malignant neoplasm of bone, and hypertension. <p>Review of Minimum Data Set (MDS) dated [DATE] (Medicare 5-day) revealed resident was cognitively intact.</p> <p>Review of current physician orders revealed Hydroxyzine (antihistamine) 25 milligrams (mg) three times daily.</p> <p>Review of late medication report revealed Hydroxyzine 25 mg was ordered at 9:00 P.M. and administered at 11:49 P.M. on 03/24/25, and Hydroxyzine 25 mg was ordered at 2:00 P.M. and it was administered at 5:41 P.M. on 03/23/25.</p> <ol style="list-style-type: none"> Review of medical record for Resident #16 revealed admitted [DATE]. Diagnoses included malignant neoplasm of upper lobe left bronchus or lung, chronic obstructive pulmonary disease, anxiety, insomnia, major depressive disorder, and muscle weakness. <p>Review of Minimum Data Set (MDS) dated [DATE] (Admission) revealed resident was cognitively intact.</p> <p>Review of current physician orders revealed Calcium (supplement) 500 plus D3 500-15 milligrams (mg)-micrograms (mcg) twice daily, Mometasone Furo-formoterol fum inhalation aerosol (steroid) 200-5 mcg/ACT twice daily, Pantoprazole (proton pump inhibitor) 40 mg twice daily, Tylenol (analgesic) extra strength 500 mg twice daily,</p> <p>Review of late medication report revealed on 03/23/25 Calcium 500 plus vitamin D3 500/15 mg/mcg , Tylenol extra strength 500 mg, Pantoprazole 40 mg, and Mometasone Furo-Formoterol Fum Inhalation Aerosol 200/5 mcg/act two puffs orally twice daily, scheduled at 7:30 A.M. were administered at 9:52 A.M.</p> <ol style="list-style-type: none"> Review of medical record for Resident #51 revealed admitted [DATE]. Diagnoses included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side, type two diabetes, metabolic encephalopathy, nontraumatic intracerebral hemorrhage, and hypertension. <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Minimum Data Set (MDS) dated [DATE] (Medicare 5-day) not completed revealed resident was cognitively intact.</p> <p>Review of MAR for March 2025 revealed medications were given except for bedtime (HS) meds on 03/13/25 Atorvastatin (statin) 80 mg, Carvedilol (lowers heart rate and blood pressure) 25 mg, Clopidogrel (platelet inhibitor) 75 mg, Dicyclomine (relieves muscle spasms in the gastrointestinal tract) 20 mg, Evolocumab subcutaneous solution auto-injector (used to treat high cholesterol) 140 mg/ml 1 ml SQ at bedtime every 14 days for high cholesterol, Gabapentin (anticonvulsant) 300 mg, Hydralazine (vasodilator) 50 mg, Lantus Solostar SQ solution pen-injector 100 unit/ml 45 units at bedtime, Macrobid (antibiotic) 100 mg for 4 days, Sodium Bicarbonate (antacid) 650 mg, Tamiflu (used to lessen influenza symptoms) 30 mg (not given on 03/14/25) started 03/15/25 for 8 days,.</p> <p>Review of late med report revealed on 03/23/25 Humulin R (insulin) injection solution 100 unit/milliliter (ml) per sliding scale 150-200 2 units, 201-250 4 units, 251-300 6 units, 301-350 8 units, 351-400 10 units, 401-500 12 units recheck blood glucose in 30 minutes, if still above 400 call provider before meals (7:30 A.M.) and it was not administered until 9:31 A.M. after breakfast.</p> <p>Review of contingency med list revealed the following medications were available to be pulled and administered on 03/13/25 on admission Atorvastatin 40 mg tablet (2 tabs to make 80 mg), Clopidogrel 75 mg, Gabapentin 300 mg, Hydralazine 25 mg tablet (2 tabs to equal 50 mg), Insulin Glargine 100 unit/ml pen.</p> <p>Observation on 03/25/25 from 8:19 A.M. to 8:30 A.M. of medication pass for three residents revealed no concerns.</p> <p>Interview on 03/25/25 at 2:43 P.M. with the Director of Nursing (DON) verified the medications listed above could have been pulled from the contingency supply for Resident #51. DON verified Residents #11, #16, and #51 had not received their medications timely.</p> <p>Review of policy titled Medication Administration not dated revealed general procedures included administer medication only as prescribed by the provider. Medications will be administered within the time frame of one hour before up to one hour after time ordered. Before meals provide medications thirty minutes prior to meal time.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163843.</p>		