

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  02/27/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528</b></p> <p>Based on staff and resident interview, medical record review, and review of facility policy, the facility failed to ensure personal property was secured and returned timely to the resident. This affected one (Resident #18) of one resident reviewed for missing personal property. The facility census was 96.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #18 revealed diagnoses including generalized anxiety and cerebral palsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had intact cognition and required assistance with activities of daily living (ADLs).</p> <p>Interview with Resident #18 on 02/24/25 at 12:26 P.M. revealed Resident #18 had multiple clothing items (shirts, pants, and socks) that were sent to laundry and never returned, including a comforter. Resident #18 stated the comforter has been missing for around two weeks now. There were approximately four T-shirts, three pairs of sweatpants, and an unknown number of socks missing. Resident #18 stated he often receives other residents' clothing.</p> <p>Interview with Laundry Aide #505 on 02/25/25 at 11:18 A.M. revealed laundry staff does not properly put clean clothes into the correct designated room area when hanging laundry to be delivered back to the residents. Laundry Aide #505 stated he has addressed this multiple times with the housekeeping supervisor. The laundry room has a list of residents rooms with names which Laundry Aide #505 said was not properly updated therefore leading to clothing being delivered to the wrong residents. Laundry Aide #505 stated he was unable to locate Resident #18's comforter and remembers when Resident #18 reported it missing to laundry.</p> <p>Interview with the Administrator on 02/25/25 at 2:34 P.M. stated if a resident has something missing, they were to report it to staff and then it was reported to corporate and then the items can be replaced.</p> <p>Review of the policy titled Personal Laundry Handling &amp; Processing Policy, undated, revealed delivery times of laundry should meet the needs of the residents. The environment supervisor should ensure that documentation is maintained for all linens that are cleaned and ready for delivery.</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
---	-------	-----------

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  02/27/2025
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39333</p> <p>Based on staff interview, review of facility policy, and record review, the facility failed to ensure baseline care plans were developed and/or summaries of the baseline care plan were provided to the residents and/or their representatives. This affected two (#79 and #81) of five residents who were reviewed for baseline care plans. The facility census was 96.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses including diabetes mellitus, vascular dementia, and hyperlipidemia.</p> <p>Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #79 was severely impaired cognition and required substantial assistance with activities of daily living.</p> <p>Review of the medical record revealed no evidence of a baseline care plan was established to address Resident #79's care needs. There was no evidence Resident #79's resident representative was provided with a copy of the baseline care plan.</p> <p>Interview with the Administrator on 02/27/25 at 3:26 P.M. verified there were no baseline plans established for Resident #79 and no evidence the representatives were given a copy.</p> <p>2. Review of the medical record for Resident #81 revealed an admitted [DATE] with diagnoses including major depressive disorder, unspecified dementia, and anxiety disorder.</p> <p>Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #81 was severely impaired cognition and required moderate assistance with activities of daily living.</p> <p>Review of the medical record revealed no evidence of a baseline care plan was established to address Resident #81's care needs. There was no evidence Resident #81's resident representative was provided with a copy of the baseline care plan.</p> <p>Interview with the Administrator on 02/27/25 at 3:26 P.M. verified there were no baseline plans established for Resident #81 and no evidence the representatives were given a copy.</p> <p>Review of the facility policy titled Baseline Care Plan dated 06/01/24 revealed a baseline care plan will be developed within 48 hours of a resident's admission which would include minimum information, a written summary of the baseline care plan will be provided to the resident and representative. There must be documentation in the medical record that the baseline care plan was provided to the resident and resident representative, either in a progress note or by utilizing a signature page.</p>		

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  02/27/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48568</b></p> <p>Based on observations, staff, family, and resident interview, review of facility policy, and record review, the facility failed to ensure activities were offered and provided to all the residents routinely. This affected two (Residents #15 and #79) of three residents reviewed for activities. The facility census was 96.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #15 revealed admitted [DATE]. Diagnoses included sequela of cerebral infarction, type II diabetes mellitus, and dementia. Resident #15's birthday was in the month of February.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had significant cognitive impairment. Resident #15 was dependent on staff for upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>Review of the care plan for Resident #15 revealed the facility will assist with transport to activities as needed and ensure activities were compatible with resident's physical and cognitive capabilities. Resident #15 would be invited to scheduled activities and provided one-to-one in room visits if unable to attend out of room events.</p> <p>Review of the activities progress note from 01/29/25 for Resident #15 revealed activity staff will continue to invite/encourage, transfer to/from, offer independent/leisure supplies, offer one-on-one activities as the resident tolerates.</p> <p>Review of the activity logs from 11/23/24 to 02/23/25 revealed Resident #15 was not offered activities on 11/25/24, 11/30/24, 12/03/24, 12/04/24, 12/05/24, 12/07/24, 12/08/24, 12/11/24, 12/14/24, 12/15/24, 12/18/24, 12/20/24, 12/21/24, 12/24/24, 12/25/24, 12/28/24, 12/29/24, 12/31/24, 01/01/25, 01/02/25, 01/03/25, 01/04/35, 01/05/25, 01/06/25, 01/07/25, 01/08/25, 01/13/25, 01/14/25, 01/15/25, 01/16/25, 01/18/25, 01/19/25, 01/21/25, 01/22/25, 01/23/25, 01/24/25, 01/25/25, 01/27/25, 01/28/25, 01/29/25, 01/30/25, 01/31/25, 02/01/25, 02/02/25, 02/03/25, 02/05/25, 02/06/25, 02/07/25, 02/08/25, 02/09/25, 02/13/25, 02/15/25, 02/16/26, 02/18/25, 02/22/25, and 02/23/25.</p> <p>Review of one-on-one activity documentation in the last three months for Resident #15 revealed one-on-one facility visits were offered six times on 12/03/24, 12/10/24, 01/07/25, 01/24/25, 02/04/25, and 02/12/25. There was no other documentation Resident #15 received one-on-one visit activities during this time period.</p> <p>Review of the February Activity Calendar revealed a Birthday Bash was taking place on 02/26/25 at 2:00 P. M. and they had a drink cart on 02/26/25 at 4:00 P.M.</p> <p>(continued on next page)</p>		

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  02/27/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations on 02/26/25 at 9:14 A.M. and 10:36 A.M. revealed Resident #15 was in her bed asleep during an activity. On 02/26/25 at 2:40 P.M., Resident #15 was in her room awake while an activity was going on three rooms down in the activity room and Resident #15 stated wanted to talk to somebody and have them stay with her. On 02/26/25 at 4:29 P.M., Resident #15 was in bed and did not get a drink from the drink cart. Resident #15 was unaware of a drink cart that came around.</p> <p>Interview on 02/26/25 at 10:48 A.M. with Licensed Practical Nurse (LPN) #303 stated the facility could do more activities and they do not provide activities for residents with a lower cognition.</p> <p>Interview on 02/26/25 at 4:32 P.M. with Activity Leader #398 stated she passed out the drinks during the drink cart activity and she was completed. Activity Leader #398 stated she did not go to Resident #15's room as she usually doesn't want it. Activity Leader #398 confirmed she did not offer Resident #15 a drink. At 4:46 P.M., Activity Leader #398 stated residents were offered activities every day and it was marked in the electronic activity log.</p> <p>Interview on 02/26/25 at 4:52 P.M. with Activities Director #385 stated activities were offered to residents daily and each resident was invited daily. Activities Director #385 confirmed activities offered were tracked on the activity log.</p> <p>At 5:15 P.M., Activities Director #385 verified the activity log showed Resident #15 was offered activities sporadically.</p> <p>Review of the facilities undated policy titled Activities Program revealed it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents.</p> <p>39333</p> <p>2. Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses including diabetes mellitus, vascular dementia, and hyperlipidemia.</p> <p>Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #79 was severely impaired cognition and required substantial assistance with activities of daily living.</p> <p>Review of Resident #79's activity tracking from 01/25/25 to 02/26/25 revealed there was no activity tracking documented for 01/29/25, 01/30/25, 01/31/25, 02/01/25, 02/02/25, 02/03/25, 02/05/25, 02/06/25, 02/07/25, 02/08/25, 02/09/25, 02/10/25, 02/11/25, 02/12/25, 02/18/25, 02/20/25, 02/21/25, 02/22/25, and 02/23/25.</p> <p>Interview on 02/24/25 at 12:34 P.M. with the wife of Resident #79 stated there were not many activities offered to her husband or available for her husband to attend.</p> <p>Interview on 02/26/25 at 5:15 P.M. with Activity Director (AD) #385 stated there was no specific calendar for the residents who resided on the secure unit but there was a guide for staff to utilize. The guide shows activity aids what they can do and puts scheduled activities on a whiteboard. AD #385 verified there multiple missing activities offered to Resident #79 from 01/25/25 to 02/26/25.</p> <p>(continued on next page)</p>

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  02/27/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/27/25 at 1:36 P.M. with Activity Aide (AA) #367 stated she was part-time activity aide for the secure unit. AA #367 stated her shift was from 9:00 A.M. through 4:00 P.M. and sometimes 3:30 P.M. to 6:00 P.M. AA #367 stated she does not work past 6:00 P.M. usually. She stated she gets a feeling from what the residents do and then does the activity. AA #367 stated today they wanted to continue with BINGO instead of singing along. AA #367 stated she documents if a resident attends activities.</p> <p>Review of the secure unit's activity guide revealed it looked like a calendar dated February 2025 which had blocks that were numbered like a calendar with times and activities listed on them. There were activities scheduled starting at 10:00 A.M. through 6:00 P.M.</p>		

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  02/27/2025
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35033</p> <p>Based on review of the medical record, observation, resident and staff interview, and policy review, the facility failed to ensure wound treatments were completed per physician orders. This affected two (#28 and #54) of three residents reviewed for wounds. The facility identified 21 residents with non-pressure wounds. The facility census was 96.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #28 had an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease, and pulmonary fibrosis. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had intact cognition.</p> <p>Review of a nurse practitioner wound note dated 02/18/25 revealed the resident had a non-pressure neuropathic wound to the left inner ankle. The wound measured 1.5 centimeters (cm) in length by 1.6 cm in width, 0.2 cm in depth. The wound base was 50% epithelial and 50% granulation tissue with attached wound edges. The surrounding skin was fragile and there was a moderate amount of serosanguineous drainage.</p> <p>Review of the physician orders dated 02/18/25 revealed an order to cleanse the left inner ankle with wound cleanser, apply calcium alginate with silver, cover with silicone bordered dressing, change daily and as needed daily on day shift for wound care and as needed for soiled/displaced dressing.</p> <p>Review of the treatment administration record dated February 2025 revealed there was no documentation the wound treatment was completed on 02/10/25 and 02/21/25. There was documentation the treatment was completed 02/22/25 and 02/23/25.</p> <p>Observation on 02/24/25 at 10:56 A.M. of Resident #28 revealed the resident's wound dressing on the left inner ankle was dated 02/20/25.</p> <p>Interview on 02/24/25 at 10:56 A.M. with Licensed Practical Nurse (LPN) #400 verified Resident #28's wound dressing was dated 02/20/25. LPN #400 stated the resident's wound dressing should have been changed daily.</p> <p>Interview on 02/24/25 at 1:08 P.M. with Resident #28 stated the nurses had not been completing the daily dressing change to his left ankle.</p> <p>Interview on 02/26/25 at 10:00 A.M. with Unit Manager Licensed Practical Nurse (UMLPN) #359 verified there was no documentation the resident's wound treatments were completed on 02/10/25 and 02/21/25. UMLPN #359 verified staff had incorrectly documented the resident's wound dressing change as completed on 02/22/25 and 02/23/25.</p> <p>Review of the undated policy Monitoring A Wound, revealed the facility would conduct daily rounds to verify the appropriate wound treatments were completed and documented and implement wound treatments as ordered.</p> <p>(continued on next page)</p>		

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  02/27/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>36650</p> <p>2. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus, morbid obesity, and stage IV chronic kidney disease.</p> <p>Review of the treatment order dated 12/16/24 for the right posterior thigh revealed to cleanse with wound cleanser, apply Hydrocolloid (a type of wound dressing that provide a moist, protective environment for wound healing) to base of the wound. Change every other day and as needed. Enhanced barrier precautions (EBP) related to wounds when providing dressing change dated 06/19/24. There was a treatment order for the bilateral posterior leg ulcers dated 02/22/25 to apply Aquaphor to bilateral leg, apply Dakin's soaked two by two (2x2) gauze pads. Secure with Kerlix and ace bandage bilaterally. Change dressings daily.</p> <p>Observation on 02/26/25 at 5:04 P.M. of Resident #54's wound care with Licensed Practical Nurse (LPN) #303 revealed LPN #303 removed the old dressing from bilateral lower leg wounds and right posterior thigh. LPN #303 did not clean the wound beds and applied triple antibiotic ointment to all the wound beds, and then applied the new dressings.</p> <p>Interview on 02/26/25 at 5:56 P.M. with LPN #303 verified she applied triple antibiotic ointment to the bed of all wound beds. LPN #303 verified she did not follow the physician orders when completing the wound dressing treatments.</p>

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  02/27/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35033</p> <p>Based on review of the medical record, observation, staff interview, and policy review, the facility failed to ensure the residents received appropriate catheter care. This affected two (#46 and #69) of two residents reviewed for catheter care. The facility identified seven residents with catheters. The facility census was 96.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #46 revealed an admitted [DATE]. Diagnoses included chronic diastolic heart failure and neuromuscular dysfunction of bladder.</p> <p>Review of the annual Minimum Data Set (MDS) assessment revealed Resident #46 had cognitive impairment and had an indwelling catheter.</p> <p>Review of the care plan last revised 02/27/22 revealed Resident #46 had an indwelling catheter for neurogenic bladder. Interventions included to secure catheter to the leg with security device.</p> <p>Review of the physician orders dated 05/15/24 revealed Foley catheter care every shift and as needed with soap and water. Secure straps if applicable, document output every shift.</p> <p>Observation on 02/24/25 at 1:16 P.M. revealed Resident #46 had an indwelling urinary catheter. The catheter tubing was not secured to the resident's leg with security device.</p> <p>Interview on 02/24/25 at 1:16 P.M. with Licensed Practical Nurse (LPN) #400 verified the urinary catheter tubing was not secured to Resident #46's leg with security device.</p> <p>2. Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included chronic cystitis, dementia, and obstructive and reflux uropathy.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had impaired cognition and had an indwelling catheter.</p> <p>Review of the care plan initiated on 02/04/25 revealed Resident #69 had a catheter related to obstructive reflux uropathy. Interventions included to secure catheter to the leg with security device.</p> <p>Review of a physician order dated 02/04/25 revealed Foley catheter care every shift and as needed with soap and water. Secure straps if applicable. Document output every shift.</p> <p>Observation on 02/24/25 at 11:10 A.M. revealed the resident's catheter was not secured to the resident's leg.</p> <p>Interview on 02/24/25 at 11:10 A.M. with Licensed Practical Nurse (LPN) #400 verified the resident's catheter was not secured.</p> <p>(continued on next page)</p>		

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  02/27/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy Catheter Care, revealed the catheter would be secured to the leg with a device or tape.</p>

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  02/27/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528</b></p> <p>Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure oxygen was administered per physician orders and further failed to ensure oxygen tubing was routinely changed. This affected two (Resident #12 and #18) of two residents reviewed for oxygen administration. The facility identified 11 residents who received oxygen therapy. The facility census was 96.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #12 revealed an admission of 07/19/17. Diagnoses included acute and chronic respiratory failure with hypoxia, atrial fibrillation, morbid obesity, and hypertensive heart disease with heart failure. Review of the Minimum Data Set (MDS) assessment revealed Resident #12 had intact cognition and required assistance with activities of daily living (ADLs).</p> <p>Review of the physician orders for Resident #12 dated 09/02/24 revealed an order for oxygen two to three liters ER minute (LPM) via nasal cannula continuous every shift with oxygenation saturations. The oxygen order was discontinued on 01/11/25.</p> <p>Observation on 02/24/25 at 9:28 A.M. revealed Resident #12 laying in bed with the head of bed elevated. Oxygen via nasal cannula was running from an oxygen concentrator at two LPM. The oxygen tubing was dated 02/10/25, with no date noted on the humidification. Resident #12 stated he was on oxygen all the time.</p> <p>Interview with Licensed Practical Nurse (LPN) 395 on 02/24/25 at 10:12 A.M. verified Resident #12 did not have an order for oxygen administration in the electronic medical record (EMR) and there were no orders for how often to change oxygen tubing and humidification. LPN #395 stated oxygen tubing should be changed weekly and verified Resident #12 oxygen tubing had a date of 02/10/25.</p> <p>2. Review of the medical record for Resident #18 revealed a diagnosis of Arnold Chiari Syndrome without Spina Bifida or Hydrocephalus and cerebral palsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively intact and required assistance with activities of daily living.</p> <p>Review of the physician orders dated 12/12/23 revealed Resident #18 had an order to provide supplemental oxygen at two liters per minute (LPM) via nasal cannula to keep oxygen saturation greater than 94 percent.</p> <p>Review of Resident #18's treatment administration record for February 2025 revealed there was no oxygen saturation documented Under vital signs, there was only one documentation of oxygen saturation at 98% on room air.</p> <p>Observation on 02/25/25 at 8:21 A.M. revealed an oxygen concentrator behind Resident #18's bed with oxygen tubing connected to the concentrator that was not dated. Resident #18 stated he wears oxygen at night when he feels short of breath, which was typically every night.</p> <p>(continued on next page)</p>		

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  02/27/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Practical Nurse (LPN) #395 on 02/25/25 at 8:21 A.M. confirmed there were no orders for oxygen as needed unless oxygen saturation drops below 94% and there was only one instance on 02/09/25 where his oxygen saturation was obtained. LPN #395 stated the oxygen tubing was typically changed weekly and verified there were no orders for how often to change it in the EMR.</p> <p>Review of the policy titled Oxygen- Medical Gas Use undated, revealed oxygen will be ordered by a physician or other authorized provider. Oxygen will be provided under the supervision of a licensed professional. Residents will have a physician/provider's order for the oxygen including route of administration, liters per minute and frequency of use.</p>

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  02/27/2025
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36650</p> <p>Based on resident and staff interviews, record review, and review of facility policy, the facility failed to monitor weights and vital signs before and after dialysis and maintain adequate communication with the outside dialysis center for Resident #66. This affected one (Resident #66) of one resident reviewed for dialysis. The facility identified four residents receiving dialysis. The facility census was 96.</p> <p>Findings include:</p> <p>Review of the medical records for Resident #66 revealed an admitted [DATE]. Diagnosis included stage III kidney disease and hemodialysis.</p> <p>The medical record for November 2024, December 2024, and January 2025 revealed there were no routine vital signs, pre or post dialysis assessments were completed. There was no dialysis communication noted in the medical record either.</p> <p>Review of the physician order dated 02/06/25 revealed to assess the resident upon return from dialysis in the afternoon every Monday, Thursday and Saturday. Complete a pre-dialysis assessment prior to dialysis on Tuesday, Thursday and Saturday.</p> <p>Interview on 02/25/25 at 1:24 P.M. with Resident #66 stated he has a port for dialysis on right chest and fistula in left arm. He goes to dialysis three times a week. Resident #66 stated he does not take any communication with him to dialysis and does not bring any communication back to the facility. Resident #66 stated the staff usually does not weigh him pre and post and staff do not complete vital signs on his dialysis days.</p> <p>Interview on 02/25/25 at 1:41 P.M. with Licensed Practical Nurse (LPN) #337 stated if a resident has changes while at dialysis, the dialysis staff will send it back with resident or call facility. Dialysis does all of their labs. LPN #337 verified pre and post assessment were to be done for all dialysis residents. LPN #337 verified the nursing staff does not send any paperwork with Resident #66 when he goes to dialysis.</p> <p>Interview on 02/26/25 at 2:00 P.M. with Regional Nurse #501 verified there was no documentation of pre, and post assessments being completed in the months of November 2024, December 2024, and January 2025. Regional Nurse #501 verified the facility does not communicate with dialysis on a regular basis.</p> <p>Review of the facility policy titled Hemodialysis Care and Monitoring dated 2017 revealed pre-dialysis evaluation completed within four hours of transportation to dialysis to include but not limited to, accurate weight, blood pressure, perspirations and temperature. Send a copy of nursing evaluation with resident to dialysis center along with MAR and emergency contact and facility contact information. Post-dialysis the nurse is to review notes from dialysis center and should be put into medical record. Nurse is to complete the post-dialysis evaluation upon return and dialysis center.</p>		

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  02/27/2025
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 0730</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>39333</p> <p>Based on record review and staff interview, the facility failed to ensure annual performance evaluations were completed as required for certified nursing assistants (CNAs). This affected three of three CNAs reviewed for annual performance evaluations. This had the potential to affect all 96 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the personnel file for CNA #302 revealed a hire date of 08/10/22. The employee's personnel file revealed no annual performance evaluation had been completed for 2024.</p> <p>Review of the personnel file for CNA #304 revealed a hire date of 11/19/19. The employee's personnel file revealed no annual performance evaluation had been completed for 2024.</p> <p>Review of the personnel file for CNA/Medication technician (MT) #360 revealed a hire date of 01/05/22. The employee's personnel file revealed no annual performance evaluation had been completed for 2024.</p> <p>On 02/25/25 at 8:20 A.M. with Human Resource Director (HR) #307 verified no 2024 annual performance evaluation had been completed for CNA #302, CNA #304, and CNA/MT #360.</p>		

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  02/27/2025
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51528</p> <p>Based on observation, resident and staff interview, medical record review, and facility policy review, the facility failed to ensure medications were administered according to physician orders resulting in a medication error rate which exceeded five percent (%). 27 opportunities were observed with two medication errors resulting in a 7.41% error rate. This affected two (Resident #57 and #69) of four residents observed for medication administration. The facility census was 96.</p> <p>Findings include:</p> <p>1. Review of the medical records for Resident #57 revealed an admitted [DATE] with a diagnosis including type II diabetes mellitus (DM) with hyperglycemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had intact cognition.</p> <p>Review of the physician order dated 02/10/25 revealed an order for Lantus SoloStar subcutaneous solution pen-injector 100 unit per milliliter (ml), inject 50 units subcutaneous twice daily for DM. (Lantus is a long-acting insulin used to control high blood sugar). The scheduled times for this medication were 7:30 A.M. and 4:00 P.M. Additional insulin orders with a start date of 02/13/25 was Insulin Aspart FlexPen 100 unit per ml solution pen-injector (Insulin Aspart was a fast acting insulin). Inject per sliding scale intradermally before meals and at bedtime for DM.</p> <p>Observation on 02/26/25 at 7:52 A.M. of medication administration for Resident #57 revealed Licensed Practical Nurse (LPN) #310 obtained a finger stick blood sugar (FSBS) for the resident with a FSBS result of 435 (normal range is less than 100). LPN #310 then removed from the medication cart a glass vial with the label Lispro (fast acting insulin and not physician ordered for Resident #57), and the Insulin Aspart FlexPen (fast acting insulin). LPN #310 then stated she was going to give 12 units of the Aspart FlexPen per the resident's sliding scale. LPN #310 then took the glass vial labeled Lispro and stated the resident gets 50 units at this time. LPN #310 then took an insulin syringe and withdrew 50 units of Lantus from the bottle and verified the correct dosage was 50 units. LPN #310 then went into Resident #57's room and injected both medications (Lantus and Insulin Aspart) into Resident #57's lower right abdomen.</p> <p>Interview on 02/26/25 at 9:56 A.M. with Director of Clinical Operations #502 verified LPN #310 gave Lispro 50 units (fast acting insulin) to Resident #57 instead of the prescribed Lantus 50 units (long-acting insulin). LPN #310 verified with Director of Clinical Operations #502 the vial of Lispro along with the Aspart FlexPen was administered to Resident #57.</p> <p>Interview with LPN #310 on 02/26/25 at 10:00 A.M. verified she withdrew 50 units of Lispro from the vial, and dialed the Aspart FlexPen to 12 units totaling 62 units of fast acting insulin administered to Resident #57. Certified Nurse Practitioner (CNP) #503 was in the facility at this time and went to Resident #57's room and obtained her FSBS with a result of 411.</p> <p>(continued on next page)</p>		

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  02/27/2025
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/26/25 at 11:05 A.M. with Resident #57 stated she was told that she was given the wrong insulin. Resident #57 stated she felt tired and out of breath and her left arm was numb, shortly after getting the insulin, more than normal and had not had anything to eat since breakfast. Resident #57 further stated she has been having crazy thoughts and was loopy, and shaky when eating breakfast, having to use her fingers to pick up food but after 20 minutes it stopped.</p> <p>Interview on 02/26/25 at 11:23 A.M. with CNP #503 stated Resident #57 has a history of numbness in her left arm due to a pinched nerve and Resident #57 told CNP #503 when she was in with her that she did not sleep well last night and was tired. CNP #503 further stated Resident #57 told her she was a little shaky this morning. CNP #503 said they would check Resident #57 FSBS every 15 minutes for three times, and then continue every hour for 24 hours. CNP #503 stated Resident #57 was insulin resistant and the extra fast acting insulin has not had an effect on her.</p> <p>Interview on 02/26/25 at 12:09 P.M. with LPN #310 stated CNP #503 placed an order to hold noon insulin at this time. FSBS was 366.</p> <p>Interview on 02/26/25 at 12:55 P.M. with Unit Manager #359 stated Resident #57's blood sugar was dropping so she was sitting with Resident #57 for the rest of the day.</p> <p>2. Review of the medical record for Resident #69 revealed a diagnosis of paroxysmal atrial fibrillation, essential hypertension, and hyperlipidemia. Resident #69 had severe cognitive impairment.</p> <p>Review of the physicians order dated 01/30/25 revealed Resident #69 had an order for Diltiazem HCL ER (treats high blood pressure) 180 milligrams (mg) coated beads give one capsule in the morning. Hold if systolic blood pressure is less than 120, and hold if heart rate is less than 60.</p> <p>On 02/26/25 at 8:22 A.M., Resident #69's heart rate was documented as 56.</p> <p>Observation on 02/26/25 at 7:38 A.M. revealed Licensed Practical Nurse (LPN) #310 prepared Resident #69's medication and administered the Diltiazem HCL ER 180 mg along with Resident #69's other medication. No vital signs were obtained during this time.</p> <p>Interview on 02/26/25 at 10:08 A.M. with LPN #310 confirmed she had documented Resident #69's heart rate at 56 and verified the Resident #69's physician orders read to hold the medication if the heart rate was below 60.</p> <p>Review of the undated policy titled Medication Administration revealed licensed and authorized personnel may administer prescribed medication and observe the five rights in giving each medication which include: the right medicine, and the right dose. The licensed personnel must read medication labels three times before administering medication. Record pertinent information prior to giving medication if appropriate, which include: blood pressure recorded, apical pulse recorded, and blood sugar recorded.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161215.</p>		

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  02/27/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528</b></p> <p>Based on observation, record review, resident and staff interview, and policy review, the facility failed to ensure that residents were free from significant medication errors. This affected one (Resident #57) of four residents reviewed for medication administration. The facility census was 96.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #57 revealed an admitted [DATE] with a diagnosis including type II diabetes mellitus (DM) with hyperglycemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had intact cognition.</p> <p>Review of the physician order dated 02/10/25 revealed an order for Lantus SoloStar subcutaneous solution pen-injector 100 unit per milliliter (ml), inject 50 units subcutaneous twice daily for DM. (Lantus is a long-acting insulin used to control high blood sugar). The scheduled times for this medication were 7:30 A.M. and 4:00 P.M. Additional insulin orders with a start date of 02/13/25 was Insulin Aspart FlexPen 100 unit per ml solution pen-injector (Insulin Aspart was a fast acting insulin). Inject per sliding scale intradermally before meals and at bedtime for DM.</p> <p>Observation on 02/26/25 at 7:52 A.M. of medication administration for Resident #57 revealed Licensed Practical Nurse (LPN) #310 obtained a finger stick blood sugar (FSBS) for the resident with a FSBS result of 435 (normal range is less than 100). LPN #310 then removed from the medication cart a glass vial with the label Lispro (fast acting insulin and not physician ordered for Resident #57), and the Insulin Aspart FlexPen (fast acting insulin). LPN #310 then stated she was going to give 12 units of the Aspart FlexPen per the resident's sliding scale. LPN #310 then took the glass vial labeled Lispro and stated the resident gets 50 units at this time. LPN #310 then took an insulin syringe and withdrew 50 units of Lantus from the bottle and verified the correct dosage was 50 units. LPN #310 then went into Resident #57's room and injected both medications (Lantus and Insulin Aspart) into Resident #57's lower right abdomen.</p> <p>Interview on 02/26/25 at 9:56 A.M. with Director of Clinical Operations #502 verified LPN #310 gave Lispro 50 units (fast acting insulin) to Resident #57 instead of the prescribed Lantus 50 units (long-acting insulin). LPN #310 verified with Director of Clinical Operations #502 the vial of Lispro along with the Aspart FlexPen was administered to Resident #57.</p> <p>Interview with LPN #310 on 02/26/25 at 10:00 A.M. verified she withdrew 50 units of Lispro from the vial, and dialed the Aspart FlexPen to 12 units totaling 62 units of fast acting insulin administered to Resident #57. Certified Nurse Practitioner (CNP) #503 was in the facility at this time and went to Resident #57's room and obtained her FSBS with a result of 411.</p> <p>Interview on 02/26/25 at 11:05 A.M. with Resident #57 stated she was told that she was given the wrong insulin. Resident #57 stated she felt tired and out of breath and her left arm was numb, shortly after getting the insulin, more than normal and had not had anything to eat since breakfast. Resident #57 further stated she has been having crazy thoughts and was loopy, and shaky when eating breakfast, having to use her fingers to pick up food but after 20 minutes it stopped.</p> <p>(continued on next page)</p>

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  02/27/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/26/25 at 11:23 A.M. with CNP #503 stated Resident #57 has a history of numbness in her left arm due to a pinched nerve and Resident #57 told CNP #503 when she was in with her that she did not sleep well last night and was tired. CNP #503 further stated Resident #57 told her she was a little shaky this morning. CNP #503 said they would check Resident #57 FSBS every 15 minutes for three times, and then continue every hour for 24 hours. CNP #503 stated Resident #57 was insulin resistant and the extra fast acting insulin has not had an effect on her.</p> <p>Interview on 02/26/25 at 12:09 P.M. with LPN #310 stated CNP #503 placed an order to hold noon insulin at this time. FSBS was 366.</p> <p>Interview on 02/26/25 at 12:55 P.M. with Unit Manager #359 stated Resident #57's blood sugar was dropping so she was sitting with Resident #57 for the rest of the day.</p> <p>Review of the undated policy titled Medication Administration revealed licensed and authorized personnel may administer prescribed medication and observe the five rights in giving each medication which include: the right medicine, and the right dose. The licensed personnel must read medication labels three times before administering medication.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161215.</p>		

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  02/27/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39333</p> <p>Based on observations, review of facility policy, and staff interviews, the facility failed to ensure clean food service areas and beard restraints were worn during food preparation. This had the potential to affect all 96 residents who received meals from the kitchen. The facility did not identify any residents who received nothing by mouth.</p> <p>Findings include:</p> <p>Observation and interview on 02/24/25 at 8:30 A.M. of the secured unit pantry revealed the microwave had dried food splatter in the inside of the microwave. This was verified by Dietary Aide #344.</p> <p>Observation and interview on 02/24/25 at 8:32 A.M. of the snack refrigerator located behind the nurses' station in the secured unit revealed there were dried liquid spills on the bottom of the refrigerator. The freezer had dried frozen liquid at the bottom of the freezer, protein balls were on a tray not covered, labeled or dated. There was a package of veggie burgers that did not have an open date. This was verified by Licensed Practical Nurse (LPN) #359 verified at 8:32 A.M.</p> <p>Observation on 02/25/25 at 4:03 P.M., revealed [NAME] #396 had a full beard that went past his chin (approximately half inch of facial hair) and was not wearing a beard net while cooking. [NAME] #396 stated he forgot to put a beard net on when he came in to work. Dietary Manager (DM) #316 gave [NAME] #396 a beard net to wear at time of observation.</p> <p>Review of the facility policy titled, Environment dated 09/2017 revealed all food preparation areas, food service areas, and dining areas will be maintained in a clean sanitary condition.</p>

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  02/27/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528</b></p> <p>Based on observation, staff interview, medical record review, review of Centers for Disease Control and Prevention (CDC) guidance, and review of the facility policy, the facility failed to ensure glucometers were properly disinfected, failed to implement enhanced barrier precautions (EBP) by donning personal protective equipment (PPE) when completing wound care, and failed to change gloves properly during wound care This affected one (Resident #57) of four residents observed for medication administrations and one (#54) of two residents observed for wound care. The facility identified five residents receiving blood glucose monitoring on the unit. The facility census was 96.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #57 revealed an admitted [DATE] with a diagnosis including type II diabetes mellitus (DM) with hyperglycemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had intact cognition.</p> <p>Review of the physician order dated 02/09/25 revealed an order for accu check twice daily and notify the physician (MD)/certified nurse practitioner (CNP) if greater than 200. Resident #57's finger stick blood sugar (FSBS) was four times a day for insulin to be administered four times daily via sliding scale insulin.</p> <p>Observation and interview on 02/26/25 at 7:52 A.M. revealed Licensed Practical Nurse (LPN) #310 obtained Resident #57's FSBS prior to administering morning insulin. LPN #310 then came back to the nurses' cart and placed the glucometer on the medication cart, took an alcohol wipe and cleaned the front and back of the glucometer. She then placed the glucometer back into the storage pouch. When asked if the glucometer was used for other residents, LPN #310 confirmed it is used for other residents on the hallway. LPN #310 confirmed she used an alcohol wipe to sanitize the glucometer. LPN #310 stated she cleaned it with alcohol to sanitize the glucometer.</p> <p>Interview with Licensed Practical Nurse Unit Manager (LPNUM) #359 on 02/26/25 at 8:18 A.M. verified the nurse should clean the glucometer with bleach sanitizer wipes and set it in a cup or on a clean towel, making sure it is wet for two minutes, and air dries completely before using again.</p> <p>Review of the undated policy titled Cleaning &amp; Disinfection of Glucose Meter revealed shared glucometers must undergo cleaning and disinfection after each resident use. Use an Environmental Protected Agency (EPA) approved disinfectant that is effective against HIV, Hepatitis C and Hepatitis B to thoroughly wet all surfaces for the time recommendation on the product. Alcohol wipes are not appropriate for cleaning/disinfecting a used glucometer.</p> <p>36650</p> <p>2. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus, morbid obesity, and stage IV chronic kidney disease.</p> <p>(continued on next page)</p>		

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  02/27/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the treatment order dated 12/16/24 revealed an order for the right posterior thigh to cleanse with wound cleanser, apply Hydrocolloid (a type of wound dressing that provide a moist, protective environment for wound healing) to base of the wound. Change every other day and as needed. Enhanced barrier precautions (EBP) related to wounds when providing dressing change dated 06/19/24. The treatment order for the bilateral posterior leg ulcers dated 02/22/25 was to apply Aquaphor to bilateral leg, apply Dakin's soaked two by two (2x2) gauze pads. Secure with Kerlix and ace bandage bilaterally. Change dressings daily.</p> <p>Observation on 02/26/25 at 5:04 P.M. of Resident #54 dressing treatments with Licensed Practical Nurse (LPN) #303 revealed LPN #303 put gloves on and did not wear a gown that was required for a resident that was on EBP. The EBP sign on Resident #54's door stated when providing personal care and wound care staff are to complete hand washing, wear gloves and gown. The old dressing was removed from Resident #54's bilateral legs. LPN #303 continued with wound care without removing the dirty gloves. LPN #303 then put triple antibiotic ointment on the dirty glove and applied it to the wounds on the left lower leg. LPN #303 did not change gloves and then continued to apply Aquaphor cream to Resident #54's left calf. After applying Aquaphor, she removed her gloves and used hand sanitizer and reapplied gloves. LPN #303 finished wrapping Resident#54's left leg and then continued to remove the old dressing from Resident #54's right lower leg, again LPN #303 did not change her glove or wash her hands after removing the old dressing. LPN #303 then applied triple antibiotic ointment to the wounds on Resident #54's right leg wound with the dirty glove and applied Aquaphor to Resident #54's right leg. LPN #303 took off the dirty gloves and applied new gloves after using hand sanitizer. LPN #303 continued to remove the dirty dressing from Resident #54's posterior thigh and knee. LPN #303 needed assistance with turning Resident #54 and put the call light on for assistance. Certified Nurses Assistant (CNA) #327 came into the room to assist LPN #303, CNA #327 did not don a gown before she assisted with the dressing change. CNA #327 assisted with turning and holding Resident #54 while LPN #303 continued to remove the dirty dressing. LPN #303 did not clean the wound prior to applying the Hydrocolloid dressing to the posterior thigh wound and wound behind the knee. After Resident #54's treatments were completed, LPN #303 and CNA #327 did not remove their gloves, and they repositioned Resident #54. CNA #327 took off their gloves when leaving Resident #54's room. LPN #303 left the room with her gloves on, and put her supplies back into the treatment cart with her gloves still on.</p> <p>Interview on 02/26/25 at 5:56 P.M. with LPN #303 verified she did not put on the appropriate PPE when providing wound care for Resident #54. She stated she should have put on a gown and gloves when a resident was on EBP. LPN #303 verified she did not change her gloves and wash her hands between removing the old dressing and new dressing.</p> <p>Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at <a href="https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html">https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html</a> and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.</p> <p>(continued on next page)</p>		

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  02/27/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of CDC guidance titled Clinical Safety: Hand Hygiene for Healthcare Workers found at <a href="https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html">https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html</a> and dated 02/27/24 revealed hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of deadly germs to patients. Recommendations included on know when to wear (and change) gloves stated gloves are not a substitute for hand hygiene. If your tasks requires gloves, perform hand hygiene before donning gloves and touching the patient or the patients surroundings; always clean your hands after removing gloves. When to change gloves and clean hands included if gloves become soiled with blood or body fluids after a task, if moving from work on a soiled body site to a clean body site on the same patient or if clinical indication for hand hygiene occurs, and before exiting a patient room.</p>		