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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365574 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/20/2025 |
| NAME OF PROVIDER OR SUPPLIER Crandall Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 800 S 15th St Sebring, OH 44672 | |
| 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 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333</p> <p>Based on medical record review, review of facility policy, and staff interview, the facility failed to ensure residents had accurate advance directive orders in place throughout their medical record and implement the facilities advance directive policy. This affected two (Residents #4 and #109) of 33 residents reviewed for advance directives. The facility census was 112.</p> <p>Findings include:</p> <p>1. Review of Resident #4's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including heart failure and fracture of the fibula. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 was cognitively intact.</p> <p>Review of the physician's orders for Resident #4 revealed an order dated 02/06/25 for a Do Not Resuscitate Comfort Care Arrest (DNRCCA) (meaning invasive or extreme life-supporting measures were allowed under any circumstance except for cardiac or respiratory arrest. In the event of cardiac or respiratory arrest only comfort measures would be initiated) code status.</p> <p>Review of the electronic chart for Resident #4 revealed a signed DNRCCA code status dated 02/06/25.</p> <p>Review of the hard medical chart for Resident #4 revealed a signed Do Not Resuscitate Comfort Care (DNRCC) code status (meaning only comfort measures would be initiated in the event of a medical emergency) dated 05/16/03.</p> <p>An interview on 03/18/25 at 9:06 A.M. with [NAME] Clerk #804 verified Resident #4's hard medical record had a signed advance directive for DNRCC, and the electronic chart had a signed DNRCCA code status.</p> <p>46195</p> <p>2. Review of medical record for Resident #109 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease and type two diabetes mellitus. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #109 was moderately impaired cognitively.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of DNR (Do Not Resuscitate) Comfort Care document, signed and dated 12/11/24 by a nurse practitioner, revealed Resident #109's code status was a DNR Comfort Care-Arrest (DNRCCA), which meant the provider would treat the resident as any other without a DNR order until the point of cardiac arrest, at which point all other interventions would cease and the DNR Comfort Care protocol would be implemented.</p> <p>Review of Resident #109's physician orders revealed there was no order indicating Resident #109's code status was a DNRCCA.</p> <p>Interview on 03/18/25 at 3:16 PM with Registered Nurse # 814 confirmed Resident #109 didn't have a physician order in the medical record indicating Resident #109 was a DNRCCA. She stated the facility audited charts monthly to ensure the signed DNR form matched the physician order in the medical record and could not give a reason why Resident #109 didn't have a physician order for DNRCCA order in place.</p> <p>Review of facilities policy titled DNR Status Policy and Procedure, updated 07/19/24, revealed every resident should have clearly stated on their chart if they wish to be a DNRCC or DNRCCA, a physician's order, and a DNR form completed and signed by the provider.</p> | | |

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| <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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51514</p> <p>Based on record review, review of facility policy, and resident and staff interview, the facility failed to ensure the residents had activities to meet their needs, especially on the weekends and evenings. This affected two (Residents #20 and #51) of two residents reviewed for activities. The facility census was 112.</p> <p>Findings include:</p> <p>1. Review of Resident #20's medical record revealed the resident was admitted [DATE] with diagnoses including legal blindness, anxiety disorder and essential hypertension. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 exhibited intact cognition.</p> <p>Review of the activity care plan dated 02/03/25 revealed Resident #20 was at risk for social isolation and low activity participation related to blindness and periods of confusion. Interventions dated 02/03/25 included interviewing the resident about past roles, monitor for activity needs, room greetings, respect the resident's preferences and offer to read the daily activity flyer in the resident's room.</p> <p>Interview with Resident #20 on 03/17/25 at 9:08 A.M. stated the facility did not usually have activities on the weekends or evenings. Resident #20 stated they were bored on the weekends without activities.</p> <p>2. Review of Resident #51's medical record revealed the resident was admitted on [DATE] with diagnoses including dementia, schizoaffective disorder and essential hypertension. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 exhibited intact cognition.</p> <p>Review of the activity care plan dated 11/04/24 revealed Resident #51 was at risk for social isolation and low activity participation related to diagnosis of pneumonia and respiratory failure. Interventions dated 11/04/24 included interviewing resident about past roles, provide calendar of daily scheduled activities with times and locations, monitor for activity needs, invite/escort to activities of choice, room greetings, and respect resident preferences.</p> <p>Interview with Resident #51 on 03/17/25 at 8:52 A.M. stated the facility did not have activities on Saturday or Sunday. Resident #51 stated when there were no activities, they were bored.</p> <p>Review of the Activity Calendar from 01/01/25 to 01/31/25 revealed no activities were scheduled for Wednesday 01/01/25 (New Years Day). Only one weekend day, Sunday 01/05/25, had an activity scheduled that was not a movie (Saturday) or church service (Sunday) on the in-house TV channel.</p> <p>The facilities Activity Calendar from 02/01/25 to 02/28/25 revealed Saturday 02/15/25 and Sunday 02/16/25 had no activities scheduled. The other activities offered on Saturday or Sunday for the month of February included a movie on Saturdays on the facility in-house TV channel or a church service on Sundays on the facility in-house TV channel.</p> <p>(continued on next page)</p> | | |

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| <p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facilities Activities Calendar from 03/01/25 to 03/18/25 revealed four evening activities were scheduled. During the rest of the time-period, the latest scheduled activity was 3:45 P.M., which indicated a lack of evening activities. During review of the same dates, no activities were scheduled for Saturday 03/15/25. The Special Events schedule for 03/2025 revealed one evening activity and one weekend activity.</p> <p>Interview with Activities Director #849 on 03/19/25 at 2:56 P.M. stated normal evening activities were typically finished around 4:00 P.M. to 4:30 P.M. Activities on the weekend were normally movies and church service broadcasted on the in-house facility station which residents can watch in their rooms or in the living room area. Director #849 stated activity staff did not normally work on Saturday or Sunday and verified the activity calendars were correct.</p> <p>Review of the facilities Activity Policy revised 08/2006 revealed activity programs were designed to meet the needs of each resident which were available daily. Activities were scheduled seven days a week and residents were given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195</p> <p>Based on observation, staff interview, medical record review, review of safety data sheets (SDS), and review of facility policy, the facility failed to ensure personal care items, which could cause harm if consumed, were out of reach of residents who were cognitively impaired and residing in the facility's memory care unit. This affected five residents (#6, #7, #49, #58, and #90) and had the potential to affect 19 residents who the facility identified who have cognitive impairment and were independently mobile. The facility identified one resident (#82) who resided on the memory care unit as being immobile. The facility census was 112.</p> <p>Findings include:</p> <p>1. Review of Resident #49's medical record revealed the resident was admitted on [DATE] with diagnoses including dementia and Alzheimer's disease, and fatigue. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 12/19/24, revealed Resident #49 was rarely/never understood and required partial/moderate assistance to walk ten feet.</p> <p>Observation of Resident #49's room located in the memory care unit on 03/17/25 at 8:28 A.M. revealed on the windowsill in Resident #49's room there was one 8.8 ounce metal spray can of air freshener with a keep out of reach of children noted on the label. On the bedside table, there was one 8.8 ounce metal spray can of air freshener with a keep out of reach of children noted on the label. In the bathroom on the open shelving next to the toilet, there was one 4.5 ounce spray can of air freshener with a keep out of reach of children and pets noted on the label, one 16 ounce plastic spray bottle of 70 percent isopropyl alcohol with keep out of reach of children, one 32 ounce plastic bottle of 91% isopropyl alcohol with a keep out of reach of children and pets noted on the label, and one 10 fluid ounce plastic bottle of nail polish remover.</p> <p>Interview on 03/17/25 at 8:30 A.M. with Memory Care Director #859 confirmed the areas of concern and stated chemicals should not be visible and kept out of reach of the residents on the memory care unit. She stated there was a locked drawer in the bedside table where care products should be kept.</p> <p>Review of the SDS, revised 07/06/15, for Isopropyl Alcohol 70 percent, indicated the product with repeated or prolonged exposure could cause irritation to skin, irritation to eyes upon contact, respiratory irritation upon inhalation, and may be harmful if ingested. If the product was swallowed, the SDS sheet indicated the physician or poison control should be contacted for current information.</p> <p>The SDS for Isopropyl for Alcohol 90 percent, undated, indicated the product can affect the central nervous system, and there were indications that short-term damage could occur in the gastrointestinal system, liver, kidney, and the cardiovascular system. This product was to be kept out of reach of children .</p> <p>The SDS for air freshener, revised 02/24/25, indicated if the product was ingested, the SDS sheet indicated one to two glasses of water should be drunk and vomiting should not be induced. Medical attention should be sought immediately if symptoms occur, and the product should be kept out of reach of children.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the SDS for Nail Polish Remover, dated 08/24/16, indicated prolonged or repeated contact could dry skin and cause irritation. Exposure to the product could increase toxic effects, and inhalation could cause central nervous system effects. The SDS indicated when the product was inhaled vomiting should not be induced, and the physician should be consulted. For skin contact, the skin must be rinsed and monitored for irritation, and the product should be kept out of reach of children.</p> <p>2. Review of Resident #58's medical record revealed the resident was admitted on [DATE] with diagnoses including dementia and Alzheimer's disease. Review of the Minimum Data Set (MDS) assessment, dated 01/26/25, revealed Resident #58 exhibited severe cognitive impairment and required supervision or touching assistance to walk ten feet.</p> <p>Observation of Resident #58's room located in the memory care unit on 03/17/25 at 7:49 A.M. revealed on the open shelving next to the toilet in the bathroom revealed, there was one air refresher 8.3 ounce metal can with keep out of reach of children and pets noted on the label, one 188 milliliter (ml) bottle of Brand #1 Aftershave Conditioner Fresh Scent with keep out of reach of children., two three fluid ounce bottle of Brand #2 After Shave Skin Conditioner Fresh Scent with a keep out of reach on the label, one 3.5 ounce of bottle of All Day Fresh Body Spray Cool Blast with keep out of reach of children.</p> <p>Interview on 03/17/25 at 8:32 A.M. with Memory Care Director #859 confirmed the areas of concern and stated chemicals should not be visible and kept out of reach of the residents on the memory care unit. She stated there was a locked drawer in the bedside table where care products should be kept.</p> <p>Review of the SDS for air refresher dated 08/01/18, indicated this product was to be kept away from children and would cause skin irritation.</p> <p>The SDS for Brand #1 Aftershave, revised date of 03/27/15, indicated the product was extremely flammable, would cause mild skin irritation, and was to be kept out of reach of children.</p> <p>The SDS for Power Stick Body Spray, dated 10/11/23, indicated the product could cause acute toxicity if not used as indicated. This product could cause mild skin irritation, and the physician should be contacted if irritation persisted.</p> <p>The SDS for Brand #2 After Shave Lotion dated 04/29/15 indicated this product contained hazardous substances and should not be swallowed. If ingested, a physician should be consulted.</p> <p>3. Review of Resident #90's medical record revealed the resident was admitted on [DATE] with diagnoses including Alzheimer's disease and dementia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 02/07/25, revealed Resident #90 exhibited severe cognitive impairment, required supervision or touching assistance to walk ten feet, and wandered one to three days during the assessment reference period.</p> <p>Observation of Resident #90's room located in memory care unit on 03/17/25 at 7:57 A.M. revealed on the open shelving in the bathroom sitting next to the toilet was one 8.8 fluid ounce plastic bottle of Beach fragrance mist with a keep out of reach of children noted on the label and one plastic two fluid ounce plastic bottle of Everlasting Love body mist with keep out of reach of children noted on the label.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Interview on 03/17/25 at 8:33 A.M. with Memory Care Director #859 confirmed the areas of concern and stated chemicals should not be visible and kept out of reach of the residents on the memory care unit. She stated there was a locked drawer in the bedside table where care products should be kept.</p> <p>Review of the SDS for fragrance spray, dated 09/10/24, indicated the product could cause serious eye irritation and mild skin irritation.</p> <p>4. Review of Resident #6's medical record revealed the resident was admitted on [DATE] with diagnoses including dementia and Alzheimer's disease. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was rarely/never understood and required supervision or touching assistance to walk ten feet.</p> <p>Observation of Resident #6's room located in the memory care unit on 03/17/25 at 7:59 A.M. revealed on the open shelving in the bathroom next to the toilet was one seven fluid ounce plastic bottle of Vanilla Scent Body Mist with keep out of reach of children noted on the label and one two fluid ounce plastic bottle of Gingerbread Latte Fragrance mist with keep out of reach of children noted on the label.</p> <p>Interview on 03/17/25 at 8:34 A.M. with Memory Care Director #859 confirmed the areas of concern and stated chemicals should not be visible and kept out of reach of the residents on the memory care unit. She stated there was a locked drawer in the bedside table where care products should be kept.</p> <p>Review of SDS for fragrance spray dated 09/10/24 indicated the product could cause serious eye irritation and mild skin irritation.</p> <p>5. Review of Resident #7's medical record revealed the resident was admitted on [DATE] with diagnoses including vascular dementia. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 12/03/24, revealed Resident #7 exhibited severe cognitive impairment and required supervision with transfers and can walk with supervision.</p> <p>Observation of Resident #7's room located in the memory care unit on 03/17/25 at 7:54 A.M. revealed on the open shelving in the bathroom next to the toilet was one seven fluid ounce plastic bottle of body mist with a keep out of reach of children noted on the label and one two fluid ounce Gingerbread Latte fragrance mist with keep out of reach of children noted on the label.</p> <p>Interview on 03/17/25 at 8:35 A.M. with Memory Care Director #859 confirmed the areas of concern and stated chemicals should not be visible and kept out of reach of the residents on the memory care unit. She stated there was a locked drawer in the bedside table where care products should be kept.</p> <p>Review of the SDS for fragrance spray dated 09/10/24 indicated the product could cause serious eye irritation and mild skin irritation.</p> <p>Review of the facility policy titled Safety and Environmental Policy, updated 05/14/24, revealed the director of the unit would perform environmental rounds daily, which included inspecting all residents' rooms and bathrooms. If personal care products were deemed a safety concern for the resident, it would be discussed with family, and all personal care items would be removed from resident bathrooms. The director would provide ongoing education to staff and family members regarding unsafe items or situations found on the unit.</p> | | |

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| <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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51514</p> <p>Based on observation, medical record review, review of facility policy, and staff interview, the facility failed to ensure Resident #55's oxygen humidification was labeled and dated and Resident #68's oxygen tubing was changed and dated per facility policy. This affected two (Residents #55 and #68) of three residents reviewed for respiratory therapy.</p> <p>Findings include:</p> <p>1. Review of Resident #55's medical record revealed the resident was admitted on [DATE] with diagnoses including heart failure, hypertensive heart disease with heart failure and depression. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had moderate cognitive impairment.</p> <p>Review of Resident #55's respiratory care plan dated 01/25/23 revealed an intervention dated 05/08/23 to administer oxygen as ordered and keep head of bed elevated due to shortness of breath when lying flat.</p> <p>Review of Resident #55's physician orders revealed an order dated 05/25/23 for oxygen therapy per nasal cannula at two liters continuous to maintain a pulse oximetry above 90% every shift.</p> <p>Observation on 03/17/25 at 8:43 A.M. revealed a disposable oxygen humidifier (a medical device used to moisten supplemental oxygen) without an open date.</p> <p>Interview on 03/17/25 at 8:47 A.M. with Licensed Practical Nurse (LPN) #932 verified the disposable oxygen humidifier was missing an open date.</p> <p>Interview on 03/20/25 at 10:08 A.M. with LPN #916 confirmed if a resident did not have an order for humidification, the facility would have to determine who placed the oxygen humidification, would determine if the humidification was needed and obtain an order or remove the humidification as necessary.</p> <p>2. Review of Resident #68's medical record revealed the resident was admitted on [DATE] with diagnoses including macular degeneration, dementia, and adult failure to thrive. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #68 seems or appears to have short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making per staff assessment for mental status.</p> <p>Review of Resident #68's Respiratory Care plan dated 06/11/24 revealed an intervention to administer and monitor the effectiveness of oxygen therapy as ordered.</p> <p>Review of Resident #68's physician orders dated 06/13/24 revealed an order for humidification to the oxygen every shift; an order dated 05/30/24 for oxygen therapy per nasal cannula at two liters continuous to maintain pulse oximetry above 90% at bedtime and in the afternoon when napping.</p> <p>(continued on next page)</p> | | |

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