STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365574	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crandall Nursing Home	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews, observations, staff interviews and facility policy review, the facility failed to maintain dignity while dining. This affected three residents (#85, #88, #93) of three reviewed for dignity. The facility census was 112.Findings include:1. Review of the medical record for Resident #85 revealed he was admitted on [DATE] with diagnoses that included dysphagia, major depressive disorder, and presence of cardiac pacemaker. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #85 was dependent on staff for activities of daily living (ADL) and had a Brief Interview for Metal Status (BIMS) score of seven indicating severe cognitive impairment.2. Review of the medical record for Resident #88 revealed he was admitted to the facility on [DATE] with diagnoses that included orthopedic aftercare, fracture of the right femur, and nocturia. Review of the MDS assessment dated [DATE] revealed Resident #88 was dependent on staff for ADL and had a BIMS score of four, indicating severe cognitive impairment.3. Review of the medical record for Resident #93 revealed he was admitted to the facility 0n 12/05/25 with diagnoses that included paroxysmal atrial fibrillation, anorexia nervosa, and hypertension. Review of the MDS assessment dated [DATE] revealed Resident #93 was dependent on staff for ADL and had a BIMS score of six, indicating severe cognitive impairment.Observation on 03/23/26 at 11:50 A.M. revealed Residents #85, #88, and #93 seated together at a table in the main common area on the second floor of the facility, central to the nursing station. Observation revealed Resident #88 with a lunch tray placed in front of him eating the lunch meal that consisted of a bacon, lettuce and tomato sandwich and macaroni salad. Resident #93 was seated directly to the right of Resident #88, and Resident #85 was seated across the table in front of Resident #88. Both Residents #85 and #93 did not have a lunch tray present.Interview and observation on 03/23/26 at 12:02 P.M. with Certified Nurse Assistant (CNA) #300 revealed Residents #85, #88, and #95 were seated at the table for their lunch meal. CNA #300 revealed Resident #88's tray arrived before Residents #85 and #93 lunch trays and would be arriving with the next meal cart. Observation revealed CNA #300 continued to provide lunch trays to random residents eating in their rooms. CNA #300 verified the above findings at the time of the interview.Observation on 03/23/26 at 12:19 P.M., approximately 17 minutes later, revealed a second meal cart arrived to the second-floor main common area. Observation revealed random staff providing lunch meal trays to random residents eating in their rooms. Residents #85 and #93's lunch meal tray was not on the second meal cart.Interview on 03/23/26 at 12:27 P.M. with Licensed Practical Nurse (LPN) #302 revealed Residents #85, #88, and #93 were seated at the table for their lunch meals. LPN #302 revealed Residents #85 and #93's lunch trays had not arrived. LPN #302 stated meal trays take a long time to be delivered. LPN #302 verified the above findings at the time of the interview.Observation on 03/23/26 at 12:28 P.M., approximately 40 minutes after Resident #88's lunch meal tray was delivered, revealed a third meal cart arrived to the second-floor main common area. Observation revealed Resident #88's lunch meal was completed, and he exited the table. Observation revealed Resident #85's lunch tray arrived and was provided to him. Resident #93's lunch meal tray was not provided at that time.Observation on 03/23/26 at 12:32 P.M., approximately two (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minutes later, Resident #95's lunch meal tray arrived and was provided to him.Interview on 03/23/26 at 12:34 P.M. with CNA #300 verified the above findings at the time of the observation.Interview on 03/24/26 at 3:10 P.M. with the Administrator verified Residents #85, #88, and #93 did not experience dignity while dining due to lunch meals trays not being delivered at the same time.Review of the facility document titled Dining Choices policy, updated 07/19/25, revealed the facility had a policy in place that residents would receive their meals along with other residents during dining services. Review of the document revealed the facility did not implement the policy.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to provide ordered mobility interventions for Resident #10. This affected one resident (#10) of one resident reviewed for range of motion. The facility census was 112.Findings include:Record review of Resident #10 revealed he was admitted [DATE] and had diagnoses including cerebral infarction, Parkinson's disease, neurocognitive disorder with [NAME] bodies, and dementia. Review of his orders revealed one dated 06/20/24 for the resident to wear a foam sleeve to the left thumb as tolerated, to be removed for skin checks and hygiene. The order was both discontinued and reordered on 03/20/26, with the clarification that it was to be done three times per day. Review of his range of motion assessment dated [DATE] revealed both hands were contracted. Review of his administration records and progress notes revealed no documentation of the foam sleeve being applied or attempted on any date. Review of his point of care charting revealed six instances from 03/20/26 to 03/23/26 where the foam sleeve was documented as reviewed.Observations on 03/23/26 at 8:59 A.M. and 3:08 P.M. revealed Resident #10 did not have any sleeve on his left thumb. His left hand was contracted into a fist with the thumb pressed between the fore and middle fingers. A foam dressing rested on top of the middle finger between it and the thumb. He was not interviewable.Interview with Registered Nurse (RN) #306 on 03/23/26 at 3:21 P.M. revealed Resident #10 was uncomfortable when too much was placed between his fingers and needed the foam dressing there to treat a moisture injury. The goal of the ordered cloth sleeve was to prevent the thumb from pressing down on the middle finger, which was accomplished with the foam dressing, so the facility was leaving it off.Interview with the Director of Nursing (DON) and RN #306 on 03/24/26 at 10:12 A.M. confirmed Resident #10's chart had no specific documentation of the ordered cloth sleeve to the thumb being applied, that it was not present during surveyor observations, and that there were no notes evidencing a rationale for it being not applied. Review of computer charting both before and after the facility's computer changeover on 02/23/26 revealed no record of the cloth sleeve being applied. RN #306 said the documentation of it being reviewed from 03/20/26 to 03/23/26 did not necessarily mean the sleeve was applied. The DON indicated at this time the sleeve application fell under the treatment record under all services rendered documented done three times per day; however, the surveyor confirmed with him at this time that record made no specific mention of the application or tolerance of the sleeve.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, observations, resident interview, staff interviews, and facility policy review, the facility failed to clearly distinguish, document and implement fall interventions to decrease the risk of falls. This affected one resident (#33) of one reviewed for falls. The facility census was 112.Findings include:Review of the medical record for Resident #33 revealed she was readmitted to the facility on [DATE], after a fall with a major injury, with diagnoses that included Alzheimer's disease, fracture of the right clavicle, and multiple fractures of left side ribs. Resident #33 was initially admitted on [DATE] with diagnoses of difficulty in walking, weakness, and fracture of radial styloid.Review of the care plan dated 04/28/25 revealed Resident #33 was at risk for falls related to a history of falls and fall related fractures with interventions that included keeping call light within reach and/or call light at hip level when in bed and within reach when in chair.Review of the progress note dated 11/30/25 at 5:14 P.M. revealed Resident #33 had a fall while ambulating, lost her balance, fell, landed on her right side and caught herself with her left wrist that resulted in an x-ray.Review of the fall investigation dated 11/30/25 revealed Resident #33 had a fall that resulted in no interventions due to isolated incident.Review of the progress note dated 12/01/25 at 10:21 A.M. revealed Resident #33 x-ray results returned a diagnosis of osteopenia. Degenerative changes to carpometacarpal joints, age indeterminate fracture in the left radial styloid, and officiation of the radiocarpal and ulnocarpal joint space with orders for ace wrap and ortho consult.Review of the progress note dated 12/05/25 at 12:28 P.M. revealed Resident #33 fall was an isolated incident with interventions of supervision with ambulation.Review of the progress note dated 12/15/25 at 7:03 A.M. revealed Resident #33 informed staff she fell in the bathroom in the morning, hit her left side with noted bruise to the left back side of rib.Review of the progress note dated 12/15/25 at 8:33 A.M. revealed Resident #33 had a new fall intervention to implement the falling star policy and protocol.Review of the fall investigation dated 12/15/25 revealed Resident #33 had a fall that resulted in a falling star protocol intervention.Review of the progress note dated 12/16/25 at 9:42 A.M. revealed Resident #33 received in-house x-ray of the left ribs.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. Resident #33 required supervision and/or touching assistance for walking and sit-to-stand and/or stand-to-sit transfers.Review of the fall risk assessment dated [DATE] revealed Resident #33 required the use of a walker, wheelchair, and/or cane.Review of the physician orders dated 03/18/26 revealed orders to implement the falling star protocol, call light at hip while in bed, and supervision for ambulation and transfers.Review of the point of care history related to ADL revealed fluctuating interventions of supervision or touching assistance to independent for functional abilities.Observation on 03/23/26 at 9:03 A.M. revealed Resident #33 was seated in her room on the edge of her bed with the door closed. Resident #33's call light was located approximately six feet away wrapped around a lamp shade. Resident #33's call light was not in reach. Observation revealed no ambulatory devices to assist Resident #33 with ambulation. Resident #33 appeared confused and continually performed sit-to-stand transfers.Observation on 03/23/26 at 9:05 A.M. revealed no staff monitoring Resident #33.Interview and observation on 03/23/26 at 10:50 A.M. with Certified Nursing Assistant (CNA) #304 revealed Resident #33 was confused, was a fall risk and continually stood up and down and walked back and forth. CNA #304 revealed she was aware Resident #33 had a fall that resulted in fractured ribs, but she did not recall when she had the fall. CNA #304 revealed Resident #33 had multiple fall interventions that included keeping her call light within reach and implementing the falling star protocol, which consisted of frequent monitoring. CNA #304 revealed Resident #33 was unable to be monitored with her door closed; however, was independent with ADL. CNA #304 entered Resident #33's room and verified Resident #33's call light being out of reach and lack of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring.Interview on 03/24/26 at 3:10 P.M. with the Administrator confirmed Resident #33 had a fall with major injury that resulted in fractured ribs and required clear fall interventions.Review of Resident #33 medical record, who admitted to the facility as a result of a fall with fracture, revealed conflicting information in varying parts of her medical record and did not reflect or designate a clear fall intervention to prevent future falls and allow staff to maintain a safe environment.Review of the facility fall document protocols documents titled Falling Star Protocol Point System Policy and Procedure and Fall Prevention Policy and Procedure, updated and revised 07/22/25, revealed the facility had a policy in place to provide the highest quality of care in the safest environment after a fall occurs by implementing an assessment to determine what protocol to initiate. Review of the policies revealed the facility had two protocols based on the results of a resident's assessment post fall. Review of the policies revealed after a fall occurs interventions would be reviewed, discussed, documented and put into place as indicated. Review of the document revealed the facility did not implement the policy.