

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365875	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER Crestmont North Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 13330 Detroit Ave Lakewood, OH 44107	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record reviews and interviews, the facility failed to ensure comprehensive care plans were initiated for all resident care needs. This affected four residents (Resident #7, Resident #11, Resident #25, and Resident #48's) out of five residents reviewed for comprehensive care plans. The facility census was 56. Findings included: 1. Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnosis included but not limited to cerebral infarction, vascular dementia, unspecified severity with other behavioral disturbance, unspecified psychosis not due to substance or known physiological condition, dementia with behavioral disturbance, hypertension, and difficulty walking. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 had intact cognition and always incontinent of bladder and bowel. Review of the laboratory results for urinalysis culture and sensitivity dated 08/26/24 revealed Resident #48 was positive for Escherichia Coli of the urine and had a urinary tract infection (UTI). Review of the physician order dated 08/26/24 revealed an order for Levofloxacin 750 milligram (MG) (antibiotic for UTI) administer one time a day for five days. Review of Resident #48's medical record revealed there was not a comprehensive care plan in place for urinary incontinence or urinary tract infections. Interview 11/21/24 at 10:59 A.M. with MDS Nurse #147 revealed she didn't know she needed to care plan for incontinence care. Interview on 11/26/24 at 8:49 A.M. with Director of Nursing (DON) confirmed care plans were not done correctly. DON reported QAPI Action Plans were initiated to address these concerns and Resident #48 had no UTI care plan. DON did not provide evidence of QAPI plans in place at the time of survey. Interview on 11/26/24 at 12:23 P.M. with Assistant Director of Nursing (ADON) confirmed care plans were not done correctly, and interventions were not updated on some of the care plans. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #25 revealed an admitted [DATE]. Diagnosis included but not limited to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, depression, anxiety disorder Review of the quarterly MDS assessment dated [DATE], revealed Resident #25 was occasionally incontinent of bladder. Interview 11/21/24 at 10:59 A.M. with MDS Nurse #147 revealed she didn't know she needed to care plan for incontinence care. Interview on 11/26/24 at 8:49 A.M. with DON confirmed care plans were not done correctly and interventions were not updated on falls care plan. Interview on 11/26/24 at 12:23 P.M. with ADON confirmed care plans were not done correctly and interventions were not updated on some of the care plans. 3. Review of the medical record for Resident #7 revealed an admitted [DATE]. Diagnosis included but not limited to cerebral infarction, unspecified dementia with behavioral disturbance, type two diabetes mellitus, major depressive disorder, seizures. Review of the quarterly MDS assessment in progress, dated 11/12/24, revealed Resident #07 was occasionally incontinent of bladder. Review of the care plan dated 08/26/19 revealed no care plan for incontinence. Interview 11/21/24 at 10:59 A.M. with MDS Nurse #147 revealed she didn't know she needed to care plan for incontinence care. Interview on 11/26/24 at 8:49 A.M. with DON confirmed care plans were not done correctly, and interventions were not updated on falls care plan. Interview on 11/26/24 at 12:23 P.M. with ADON confirmed care plans were not done correctly and interventions were not updated on some of the care plans. 4. Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnosis included but not limited to chronic kidney disease, schizoaffective disorder and major depressive disorder. Review of the quarterly MDS assessment, dated 08/26/24/24, revealed Resident #11 was occasionally incontinent of bladder and bowel. Review of the care plan dated 08/26/19 revealed no care plan for incontinence. Interview 11/21/24 at 10:59 A.M. with MDS Nurse #147 revealed she didn't know she needed to care plan for incontinence care. Interview on 11/26/24 at 8:49 A.M. with DON confirmed care plans were not done correctly. DON reported she didn't realize the large knowledge deficit of the MDS #147 had and education was provided to her. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/26/24 at 12:23 P.M. with ADON confirmed care plans were not done correctly, and interventions were not updated on some of the care plans. Review of facility policy, Charting and Documentation, revised July 2017, revealed documentation in the medical record will be complete and accurate. Review of facility policy, Care Plans, Comprehensive Person - Centered, revised December 2016, revealed a comprehensive, person-centered care plan to meet resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. This deficiency represents non-compliance investigated under Complaint Number OH00159309.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review and interviews, the facility failed to ensure comprehensive care plans were revised to reflect new fall interventions. This affected three residents (Resident #7, Resident #25, and Resident #48) out of five residents reviewed for comprehensive care plans. Findings included: 1. Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnosis included but not limited to cerebral infarction, vascular dementia, unspecified severity with other behavioral disturbance, unspecified psychosis not due to substance or known physiological condition, dementia with behavioral disturbance, hypertension, and difficulty walking. Review of care plan dated 09/11/20 revealed Resident #48 had a fall on 10/31/24 and the care plan was not revised to reflect new interventions of non skid socks when out of bed to prevent falls. Interview on 11/26/24 at 8:49 A.M. with Director of Nursing (DON) confirmed care plans were not done correctly and fall interventions were not updated on the care plan. 2. Review of the medical record for Resident #25 revealed an admitted [DATE]. Diagnosis included but not limited to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, depression, anxiety disorder Review of Resident #25's medical record revealed the resident had a fall on 08/06/24 with the intervention of educate on use of call light to prevent further falls. The care plan dated 07/31/23 was not revised with the call light education. Interview on 11/26/24 at 8:49 A.M. with DON confirmed Resident #25's care plan was not revised to reflect new fall interventions. 3. Review of the medical record for Resident #7 revealed an admitted [DATE]. Diagnosis included but not limited to cerebral infarction, unspecified dementia with behavioral disturbance, type two diabetes mellitus, major depressive disorder, and seizures. Review of Resident #7's medical record revealed the resident has a fall on 08/10/24 with a new intervention of offer assistant with toileting at bed. The care plan dated 08/26/19 revealed the new intervention was not added to the care plan. Interview on 11/26/24 at 8:49 A.M. with DON confirmed Resident #7's care plan was not revised to reflect new fall interventions. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Care Plans, Comprehensive Person - Centered, revised December 2016, revealed a comprehensive, person-centered care plan to meet resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change. This deficiency represents non-compliance investigated under Complaint Number OH00159309.		

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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** 43061 Based on record review and interviews, the facility failed to ensure residents were timely assessed for risk of falls to ensure appropriate interventions were in place to prevent falls. This affected three residents (Resident #11, Resident #21, and Resident #48) out of five residents reviewed for accident hazards. Findings included: 1. Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnosis included but not limited to cerebral infarction, vascular dementia, unspecified severity with other behavioral disturbance, unspecified psychosis not due to substance or known physiological condition, dementia with behavioral disturbance, hypertension, and difficulty walking. Review of the falls risk assessment revealed Resident #48's latest fall risk assessments were completed on 10/02/24 and 10/31/24. Prior to 10/31/24 the resident was not assessed for falls since 03/08/21. Interview on 11/26/24 at 8:49 A.M. with Director of Nursing (DON) confirmed falls risk assessments were not being completed as required. 2. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnosis included but not limited major depressive disorder, and chronic viral hepatitis C. Review of the falls risk assessment revealed Resident #21's fall risk assessment completed on 10/06/24. There was no evidence the resident's risk of falls were assessed upon admission to ensure appropriate fall prevention interventions were in place. Interview on 11/26/24 at 8:49 A.M. with DON confirmed falls risk assessments not being completed as required. Interview on 11/26/24 at 12:23 P.M. with Assistant Director of Nursing (ADON) confirmed falls risk assessments not completed as required. 3. Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnosis included but not limited to chronic kidney disease, schizoaffective disorder and major depressive disorder. Review of the falls risk assessment revealed Resident #11's last fall risk assessment was completed 11/17/24. Prior to 11/17/24, the resident's risk of falls was not assessed since 03/10/21. Interview on 11/26/24 at 8:49 A.M. with DON confirmed falls risk assessments were not being completed as required. Interview on 11/26/24 at 12:23 P.M. with ADON confirmed falls risk assessments not completed as required. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the QAPI Action Plan dated 11/15/24 for Quarterly Assessments timely completion, revealed the facility initiated a plan to address timely assessments dated for 11/22/24 which identified need for additional nursing hours to complete quarterly assessments. ADON/Designee was to complete or delegate risk assessments. Review of the facility policy, Fall Risk Assessment revised December 2007, revealed staff will identify and document resident risk factors for falls and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. Review of the facility policy, Falls and Fall Risk Managing revised in December 2007, revealed based on previous evaluations and current date the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. This deficiency represents non-compliance investigated under Complaint Number OH00159309.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on interviews and record reviews, the facility failed to ensure residents were administered medication per physician orders. This affected two residents (#7 and #48) out of three residents reviewed for medication administration. Findings included: 1. Review of the medical record revealed Resident ##7 revealed an admitted [DATE]. Diagnosis included but not limited to cerebral infarction, unspecified dementia with behavioral disturbance, type two diabetes, major depressive disorder, and seizures. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had intact cognition. Review of the laboratory results for urinalysis culture and sensitivity dated 08/04/24 revealed Resident #7 was positive for Staphylococcus Haemolyticus of the urine and had a urinary tract infection (UTI). Review of the physician order dated 08/04/24 revealed an order for Macrobid (antibiotic) 100 milligrams (mg) every twelve (12) hours for five (5) days. Review of the medication administration records (MAR) dated August 2024 revealed Resident #7 received Macrobid (antibiotic for UTI) 100 mg on 08/05/24 at 9:00 A.M. but did not receive the evening dose at 9:00 P. M. as ordered per physician. The MAR had a #9 code, indicating other and to see nurses' notes with initials for Licensed Practical Nurse (LPN_ #106. On 08/06/24 Macrobid 100 mg was administered twice a day (BID) as ordered. The MARS for 08/07/24, 08/08/24, and 08/09/24 were blank. Review of the paper MARS dated August 2024 revealed for 08/07/24, 08/08/24, and 08/09/24 Resident #7 reviewed Macrobid 100 mg BID as ordered per physician. Interview on 11/26/24 at 10:43 A.M. with Director of Nursing (DON) confirmed Resident #7 missed the evening dose of Macrobid 100 mg on 08/05/24. DON reported she did not know why it wasn't administered. DON reported there was a starter box in the facility which carries the antibiotic. Review of facility policy, Medication Utilization and Prescribing - Clinical Protocol, revised July 2016, revealed staff will ensure medications are given appropriately. Review of facility policy, Antibiotic Stewardship - Orders for Antibiotics, revised December 2016, revealed antibiotics will be prescribed and administered under the guidance of the facility's Antibiotic Stewardship Program and in conjunction with the facility's general policy for Medication Utilization and Prescribing. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of medical record revealed Resident #48 was admitted to the facility on [DATE]. Diagnosis included but not limited to cerebral infarction, vascular dementia, unspecified severity with other behavioral disturbance, unspecified psychosis not due to substance or known physiological condition, dementia with behavioral disturbance, hypertension, and difficulty walking. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 had intact cognition. Review of the laboratory results for urinalysis culture and sensitivity dated 08/26/24 revealed Resident #48 was positive for Escherichia Coli of the urine and had a urinary tract infection (UTI). Review of the physician order dated 08/26/24 revealed an order for Levofloxacin 750 milligram (MG) (antibiotic for UTI) administer one time a day for five days. Review of the medication administration records (MAR) dated October 2024 revealed Resident #48 received Levofloxacin 750 mg on 08/26/24, 08/27/24 and on 08/29/24. On 08/28/24 it was coded #3, absent from home as she did not receive any Levofloxacin 750 mg on 08/28/24. Resident #48 missed two doses of her antibiotic in total. Interview on 11/26/24 at 10:43 A.M. with DON confirmed the order was entered incorrectly and Resident #48 missed 3 doses of Levofloxacin 750 mg. DON reported she did not know why it wasn't administered. DON reported there was a starter box in the facility which carries the antibiotic. Review of facility policy, Medication Utilization and Prescribing - Clinical Protocol, revised July 2016, revealed staff will ensure medications are given appropriately. Review of facility policy, Antibiotic Stewardship - Orders for Antibiotics, revised December 2016, revealed antibiotics will be prescribed and administered under the guidance of the facility's Antibiotic Stewardship Program and in conjunction with the facility's general policy for Medication Utilization and Prescribing. This deficiency represents non-compliance investigated under Complaint Number OH00159309.		