STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365875	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestmont North Nursing Home	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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident that care plan meetings were held quarterly as required. This affected three (Residents #23, #48, and #66) of three residents reviewed for care plan meetings. The facility census was 62.Findings include:1. Review of the medical record revealed Resident #66 was admitted on [DATE] with diagnoses including schizoaffective disorder-bipolar type, anxiety disorder, alcohol dependence, and dementia with mood disorder. The resident was discharged on 03/25/26.Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] showed Resident #66 had severely impaired cognition, no behaviors, and required total staff assistance for bed mobility and transfersReview of the Care Conference Forms, notes, and emails showed care conferences were held on 07/17/25, 01/23/26, 02/03/26, and 03/10/26. There were no documented care conferences from admission until 07/17/25, nor between 07/17/25 and 01/23/26, as required.2. Review of the medical record for Resident #23 revealed an admission date of 01/22/25 with diagnoses including dementia, type II diabetes mellitus, anxiety, and gastro-esophageal reflux disease (GERD). The only care plan meeting available was 05/07/26, nearly 15 months after admission. Review of the Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #23 had severely impaired cognition.3. Review of the medical record for Resident #48 revealed an admission date of 12/12/25 with diagnoses including opioid dependence, nicotine dependence, cannabis abuse, GERD, chronic obstructive pulmonary disease (COPD), post-traumatic stress disorder (PTSD), paraplegia, major depressive disorder, and psychoactive substance abuse with psychoactive substance-induced dementia. Resident #48 had a Legal Guardian. The only care conference available was dated 06/04/26, six months after admission.Review of the Quarterly MDS 3.0 assessment dated [DATE] revealed resident #48 was cognitively intact. During an interview on 06/09/26 at 2:40 P.M., the Director of Nursing (DON) confirmed that no additional care conference documentation was available for any of the above residents.This deficiency represents non-compliance investigated under Complaint Number 1367131 (OH00166888).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that a resident with severe cognitive impairment was not permitted to sign financial documents. This affected one resident (Resident #66) out of three residents reviewed for protection and management of personal funds. The facility census was 62.Findings include: Review of the medical record revealed Resident #66 was admitted on [DATE] with diagnoses including schizoaffective disorder-bipolar type, anxiety disorder, alcohol dependence, and dementia with mood disturbance. The resident was discharged on 03/25/26.Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] showed Resident #66 had severely impaired cognition.Review of guardianship documentation showed Resident #66 previously had a temporary guardian appointed from 10/01/18 through 02/10/19.Review of financial records showed Resident #66 signed an Authorization to Manage Resident Funds on 02/02/25. The resident later refused to sign trust account statements dated 09/30/25 and 12/31/25.During an interview on 06/09/26 at 9:40 A.M., the Administrator stated that the resident's niece initially volunteered for guardianship in August 2025. The resident's daughter, living in California, objected, so the facility assisted the daughter in obtaining guardianship. The daughter had not been involved in the resident's care at either the prior or current facility before that time.Review of the guardianship order showed Resident #66's daughter was appointed guardian on 01/23/26.During an interview on 06/09/26 at 2:26 P.M., the Administrator confirmed the facility allowed Resident #66 to sign her own financial documents despite her severely impaired cognition.This deficiency represents non-compliance investigated under Complaint Number 1367131 (OH00166888).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THIS IS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on Self-Reported Incident Review (SRI), facility timeline, and facility policy review, medical record review and interview, the facility failed to ensure resident narcotic and anti-anxiety medications were not misappropriated. This finding affected three (Residents #26, #56 and #67) of four residents reviewed for misappropriation. The facility census was 62.Findings include: Review of the SRI Tracking #274552 dated 05/14/26 revealed a discovery of as needed doses of narcotic and anti-anxiety medications were missing. The SRI was unsubstantiated due to inconclusive evidence.Review of the undated facility investigation timeline revealed on 05/10/26 at approximately 11:30 A.M., Licensed Practical Nurse (LPN) #848 discovered two oxycodone narcotic tablets had been removed from Resident #67's oxycodone narcotic medication administration card and replaced with loratadine antihistamine tablets and then taped over the back. LPN #848 further discovered two of Resident #56's Ativan (lorazepam) antianxiety tablets were replaced with loratadine antihistamine tablets and then taped over the back. LPN #848 contacted LPN Assistant Director of Nursing (ADON) #804. LPN #848 immediately audited all narcotic drawers and discovered that Resident #26 was missing one Ativan antianxiety tablet. The missing Ativan antianxiety tablet slot in the medication card was empty and not substituted like Residents #56 and #67 medication cards.Review of Resident #26's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, hypertension and dementia.Review of Resident #26's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #26's physician order dated 11/11/25 for lorazepam 0.5 milligrams (mg) every four hours as needed for anxiety/restlessness.Review of Resident #56's medical record revealed the resident was admitted on [DATE] with diagnoses including anxiety disorder, depression and chronic obstructive pulmonary disease.Review of Resident #56's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #56's physician orders revealed an order dated 04/25/26 (discontinued 05/07/26) for lorazepam oral tablet 0.5 mg give one tablet by mouth every eight hours as needed for anxiety for 30 days; and an order dated 05/08/26 for lorazepam oral tablet 0.5 mg give one tablet by mouth every eight hours as needed for anxiety.Review of Resident #67's medical record revealed the resident was admitted on [DATE] with diagnoses including hypotension, anxiety disorder and transient cerebral ischemic attack.Review of Resident #67's Annual MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #67's medical record revealed an order dated 01/21/26 for oxycodone 5 mg give one tablet by mouth every six hours as needed for pain.During an interview on 06/09/26 at 2:27 P.M., the Director of Nursing (DON) revealed the police were contacted, the Medical Director was contacted, all residents controlled medications were audited, all staff were educated, and LPN #907 no longer worked in the facility. The DON requested past non-compliance (PNC).The deficiency was corrected on 05/15/26 when the facility implemented the following corrective actions:-On 05/10/26 LPN #907 worked from 7:00 P.M. to 7:00 A.M. and then counted Medication Cart A with LPN #847 and no concerns were identified with the narcotic count at that time. LPN #907 clocked out at 7:43 A.M. -On 05/10/26, LPN #848 who worked from 7:00 A.M. to 7:00 P.M., was counting the narcotics to take over Medication Cart A with LPN #847 who became ill during her shift. LPN #848 identified Resident #67's oxycodone narcotic card was taped and two of the pills were replaced with loratadine antihistamine tablets.-On 05/10/26, LPN #848 audited the remaining controlled medication cards in Medication Cart A and identified concerns with Residents #26 and 56's controlled medication administration cards.-On 05/11/26, the DON reviewed the facility video surveillance and observed LPN #907 placing tape on the back of a resident's medication card. -On 05/11/26 the DON interviewed LPN #907 who stated that she gave Resident #67 two tablets of the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxycodone 5 mg that was previously discontinued by accident and that she thought it was the resident's current Ativan medication. LPN #907 revealed she did not report the error because she was scared and self-terminated on this date following the interview. -On 05/11/26, the DON educated all nursing staff on medication administration, the seven resident rights of medication administration, the narcotic policy and the wasting policy.-On 05/12/26, DON #908 and Administrator #909 from a sister facility contacted the pharmacy to discuss details of the medication error and reporting needs. The pharmacy confirmed no further reporting was required.-On 05/14/26, DON #908 from a sister facility arrived at the facility and audited narcotic cards and copied all the narcotic cards and pharmacy narcotic tracking sheets for Residents #26, #56 and #57.-On 05/14/26, DON #908 from the sister facility audited all controlled medications for all residents in the facility.-On 05/15/26, DON #908 from the sister facility contacted the local police about the misappropriation, police report number 26001323.-On 05/15/26, DON #908 from the sister facility called the Medical Director to report the misappropriation.-On 05/15/26, DON #908 contacted the Ohio Board of Nursing for LPN #907's misappropriation of narcotics.-The DON was to complete controlled medication audits five times a week for one week and then three times a week for three weeks and then as needed.-The DON stated the misappropriation will be brought to the QA Committee on 06/17/26.This deficiency represents non-compliance investigated under Complaint Number 2659061.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility policy, the facility failed to ensure Resident #66's skin was assessed per the physician's orders. This finding affected one (Resident #66) of three residents reviewed for wound care. The facility census was 62.Findings include: Review of Resident #66's medical record revealed the resident was admitted on [DATE] and discharged on 03/25/26 with diagnoses including schizoaffective disorder-bipolar type, chronic obstructive pulmonary disease, and generalized anxiety.Review of Resident #66's physician orders revealed an order dated 01/14/25 (discontinued 03/27/26) for weekly skin assessments on shower days. Document under assessments every day shift on Tuesday and Friday.Review of Resident #66's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.Review of Resident #66's Weekly Skin Data Collection dated 01/09/26 revealed the resident had no new skin issues and a head-to-toe skin observation was completed. No further skin assessments were completed from 01/01/26 to 03/25/26.Review of Resident #66's medical record, skin assessments and progress notes from 01/01/26 to 03/25/26 did not reveal evidence of skin assessments (except for 01/09/26).During an interview on 06/09/26 at 8:00 A.M., the Director of Nursing (DON) confirmed Resident #66's medical record did not have evidence of skin assessments from 01/01/26 to 03/25/26 when the resident was discharged to a hospice facility.Review of the undated Wound Prevention policy revealed weekly skin checks would be conducted by the licensed nurse. This would be documented in the resident's Electronic Medical Record (EMR).This deficiency represents non-compliance investigated under Complaint Number 1367131 (OH00166888).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and review of facility policy, the facility failed to ensure medications for Resident #4 were administered as ordered. A total of 27 medications were administered with two medications omitted, for a total of 29 medication opportunities. Three medication errors were identified, resulting in a medication error rate of 10.34%. This deficiency affected one resident (Resident #4) of four residents reviewed for medication administration. The facility census was 62.Findings include: Review of Resident #4's medical record showed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, mild cognitive impairment, and anxiety disorder.Review of the physician orders for Resident #4 revealed the following active orders dated 10/10/23:-Aspirin 81 milligrams (mg) chewable tablet, administer one tablet by mouth once daily for hypertension.-Thiamine 50 mg, administer one tablet by mouth three times daily as a vitamin supplement.-Cholecalciferol 25 micrograms (mcg), administer two tablets by mouth once daily for vitamin D deficiency.Review of Resident #4's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated the resident had intact cognition.During an observation on 06/08/26 at 7:46 A.M., Licensed Practical Nurse (LPN) #805 administered 10 medications to Resident #4. Three medication errors were observed. LPN #805 administered aspirin enteric-coated (EC) 81 mg instead of the ordered aspirin 81 mg chewable. In addition, the nurse failed to administer the ordered cholecalciferol 25 mcg (two tablets) and thiamine 50 mg.During an interview on 06/08/26 at 10:01 A.M., LPN #805 confirmed the above findings.Review of the facility's Medication Administration Policy dated 02/2012 states that medications shall be administered in a safe and timely manner and as prescribed.This deficiency is an incidental finding identified during the complaint investigation.