

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365934	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Crestwood Ridge Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 141 Willettsville Pike Hillsboro, OH 45133	
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 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** 49039 Based on record review, policy review, review of the weather condition, review of Centers for Disease Control and Prevention (CDC) guidance, and resident and staff interviews, the facility failed to ensure staff provided adequate supervision to prevent a resident from being treated for hyperthermia during extreme weather conditions. This affected resident (Resident #8) of three residents reviewed for accidents. The facility census was 48. Findings include: Review of the medical record revealed Resident #8 was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis, asthma, muscle wasting and atrophy, muscle weakness, and bipolar disorder. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 was cognitively intact, required supervision with wheeling 150 feet, and rejected care. Resident #8 felt it was somewhat important to go outside and get fresh air when the weather was nice. Review of the care plan dated 06/20/24 revealed Resident #8 has a history of refusing medication and treatment. Interventions included staff were required to provide drinks frequently, monitor and assess for behaviors, document and notify physician of increased behaviors. Review of the focus alteration in mood with depression/anxiety found staff were required to ensure the resident's psychological needs were met. The resident was non-complaint with safety measures. Interventions included to document educational attempts made with resident and inform of negative outcomes related to non-compliance, and notify the medical doctor or nurse practitioner of non-compliance. Review of the medical record from 06/18/24 to 07/13/24 revealed there was minimal documentation regarding Resident #8's refusal of care and education of the health risks with refusal of specific care. On 06/19/24 and 06/20/24, Resident #8 refused morning medications. On 06/25/24, it was documented that Resident #8 was offered sunscreen several times but declined each time. On 07/01/24, Resident #8 refused Eliquis (a medication to thin blood). On 07/02/24, Resident #8 refused morning medications. There was no documentation of the resident refusing to come inside during extreme weather conditions and/or education to come inside if there was extreme weather conditions. There was no documentation to support staff provided increased supervision and fluids during extreme weather conditions. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365934	Facility ID: 365934 If continuation sheet Page 1 of 4

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care (POC) records for Resident #8 for 07/13/24 revealed specific timings documented as seen at 11:20 A.M. for hygiene (POC), and 12:41 P.M. for Bowel Movement (POC) and 3:59 P.M. for eating (POC). No additional encounters were found for 07/13/24 Review of the progress notes dated 07/13/24 at 5:24 P.M. indicated Resident #8 exhibited altered mental status, confusion, low blood pressure (134/44), and high temperature (103 Fahrenheit (F)). A medical doctor was promptly notified and ordered the transfer of the resident out of the building by 5:35 P.M. Further notes at 9:57 P.M. reported that the resident was flown to the local hospital due to urosepsis. Review of the physician orders dated 07/13/24 revealed instructions to send to the emergency room due to elevated temperature, low blood pressure, and altered mental status. Review of the pre-hospital care report dated 07/13/24 revealed Medic 223 was called to Resident #8's room for fever and low blood pressure with confusion. Staff member informed crew that she believes the resident was having a stroke or a heat stroke. Staff were unable to provide detailed events leading up to episode, last known well estimated as approximately one hour prior to calling Emergency Medical Services (EMS) (07/13/24 at 4:20 P.M.). Resident #8 was found to be confused, incoherent, speaking in short phrases, her skin was extremely hot, with remarkable erythema (skin redness) throughout and especially in face. Temporal artery obtained as 108.1 F, second attempt taken with read at 106.6 degrees F. The emergency room (ER) called EMS and asked EMS if they have the sunburn patient. The ER reported the facility called in report and stated Resident #8 was left outside for undetermined amount of time and may be having a heat stroke and sun poisoning. Review of the hospital records dated 07/13/24 for admission and discharge on 07/16/24 indicated Resident #8 arrived at the hospital with hyperthermia (106.6 F), confusion, deficits in bilateral lower extremities, and possible new hand contractures. Diagnoses included hyperthermia, urinary tract infection, left lower lobe pulmonary nodule, and hypotension. ER course included active cooling measures which included cooling blankets, status post one liter of cool water through intravenous and temperature decreased from 104 F to 100 F. The resident was reportedly outdoors for unknown amount of time on an extremely hot day with outdoor temperature at 90 F or higher. The resident presented with severe hyperthermia (temperature greater than 104 F), which improved and eventually resolved following multiple treatments. The physician documented although urosepsis can incite fever, temperatures to this severity and with such acuity in unlikely due to infection alone. Resident #8 was treated for urinary tract infection (UTI). Fever present upon admission more likely due to heat-related illness than infection due to rapid resolution. Interview on 07/18/24 at 9:17 A.M. with Licensed Practical Nurse (LPN) #17 confirmed staff should increase supervision and hydration when residents were sitting outside in the sun all day. Interview on 07/18/24 at 9:19 A.M. with Resident #8 stated she was outside everyday, and was able to self propel in the wheelchair. Resident #8 does not remember anything from 07/13/24. Observation on 07/18/24 between 11:00 A.M. and 11:06 A.M. with Resident #1, Resident #7 and Resident #8 revealed no staff members were outside with residents. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/18/24 at 11:00 A.M. with Resident #1 stated Resident #8 was acting normal on 07/13/24 before and after she was sent inside. Resident #1 stated staff did not check on them for over two and a half hours on 07/13/24. However, she stated the staff typically come out every hour to check on residents. Interview on 07/18/24 at 11:06 A.M. with Resident #7 confirmed Resident #8 was outside most of the day on 07/13/24. Interview on 07/18/24 at 10:33 A.M. with Licensed Practical Nurse (LPN) #24 confirmed Resident #8 was outside in the courtyard on 07/13/24 for a significant amount of time. The resident received a medication at 5:17 P.M., and was sent out to the hospital at 5:47 P.M. LPN #24 suspected heatstroke when the Medication Aide requested her help in the resident's room. After assessing the resident, LPN #24 notified the physician, who promptly ordered the resident to be transferred to the hospital. During the assessment, LPN #24 observed that the resident was not sweating and had excessively hot skin. Interview on 07/18/24 at 12:30 P.M. with Dietary Aide (DA) #5 stated he was responsible for the 07/13/24 at 2:00 P.M. smoke break which lasted about 25 minutes. DA #5 stated Resident #8 was already outside when he went to start the smoke break. DA #5 offered to assist all residents inside after the break. Resident #8 refused. DA #5 was concerned with Resident #8's energy, attitude, and overall appearance. He stated she looked and acted off. He denied notifying nursing staff of this change. DA #5 denied seeing Resident #8 after he came back inside from smoke break. Interview on 07/18/24 at 12:49 P.M. with State tested Nursing Assistant (STNA) #38 stated she was not concerned with Resident #8 until she came up to this STNA sometime after the 2:00 P.M. smoke break voicing she was tired and was not feeling herself. STNA #38 asked STNA #41 for assistance with getting Resident #8 changed and back to bed which was around 3:50 P.M. The medication aide was the staff member who notified nursing staff of a change in condition, she stated the resident felt like her skin was on fire. Resident #8's vital signs were taken and it was found her temperature was at 103 degrees F. Interview on 07/18/24 at 12:50 P.M. with STNA #41 confirmed she changed and assisted Resident #8 to bed with the assistance of STNA #38. During this encounter, STNA #41 stated she didn't observe any health concerns. Interview on 07/18/24 at 1:04 P.M. with Medication Aide #28 confirmed she was assigned to Resident #8. She identified the change in condition for Resident #8 around 5:22 P.M. where she looked weaker and was showing sign of a stroke. The nurse assessed her and found she had a temperature of 104.9 degrees F. The nurse notified the doctor who sent orders to send the resident out for further evaluation. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/18/24 at 1:20 P.M. with Corporate Nurse #200 stated Resident #8's main diagnosis was urosepsis and the high fever could be from urosepsis alone. Corporate Nurse #200 verified there was no documentation of increased supervision levels during extreme weather conditions for Resident #8, no documentation of education to Resident #8 for extreme weather conditions, and no documentation of Resident #8's request to stay outdoors despite education. Corporate Nurse #200 verified the facility did not complete an investigation into the incident on 07/13/24 for Resident #8 being left outdoors for an unknown amount of time in extreme weather and being treated for hyperthermia in the ER. Corporate Nurse #200 explained they did not do an investigation because the primary diagnosis was urosepsis in the hospital. Interview on 07/18/24 at 1:41 P.M. with Medical Director #101 confirmed the resident has a history of non-compliance. He stated he was not notified Resident #8 refused to come inside on 07/13/24 and he was only notified of the change in condition. Nursing staff reported an elevated temperature of 103 degrees F and said she was sitting outside and would not come in. With Resident #8's presentation of symptoms, he was initially concerned she was exhibiting neuroleptic malignant syndrome which can mimic heatstroke. He placed an order for nursing staff to send to the hospital for further evaluation. His professional opinion felt Resident #8's diagnosis of urosepsis was an appropriate diagnosis for Resident #8 signs and symptoms exhibited on 07/13/24. Review of the weather report dated 07/13/24 for Hillsboro revealed between 12:55 P.M. to 3:55 P.M. found temperatures outside ranged between 88-90 degrees F. Review of the facility's Accidents/Hazards policy, undated, revealed the interdisciplinary team will implement interventions to reduce hazards that are consistent with a residents needs, goals, plan of care, and will include adequate supervision based on residents needs. Review of CDC guidance titled Heat and Chronic Condition dated 02/15/24 and found at https://www.cdc.gov/extreme-heat/risk-factors/extreme-heat-and-chronic-conditions.html revealed extreme heat can be dangerous for anyone, but it can be especially dangerous for those with chronic medical conditions. People with chronic medical conditions are more vulnerable to extreme heat because they may be less likely to sense and respond to changes in temperature, they maybe taking medications that can make the effect of extreme heat worse, and conditions like heart disease, mental illness, poor blood circulation, and obesity are risk factors for heat-related illness. This deficiency represents non-compliance investigated under Complaint Number OH00155804.		