

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

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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 08/10/2024
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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on record review and interview the facility failed to ensure Resident #49's legal guardian was provided, in writing a transfer/discharge notice at the time the resident was transferred to the hospital as required. This affected one resident (#49) of three residents reviewed for hospitalization . The facility census was 47. Findings include: Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including unspecified psychosis, post-traumatic stress disorder, Bipolar disorder, schizoaffective disorder, chronic obstructive pulmonary disease, suicide attempts, and intellectual disabilities. Review of admission records revealed this resident had a court appointed guardian, with an effective date of 06/13/22. The resident also had a Medicaid payor source. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had a Brief Interview Mental Status (BIMS) score of ten out of 15 which indicated she had moderate cognitive impairment. Review of a nursing progress note dated 07/26/24 at 9:50 P.M. revealed the resident was sent to the emergency room after confiding in this nurse that she swallowed two AAA batteries. Room checked and found remote on bed without batteries, trash checked, drawers checked. Resident adamant about swallowing batteries. The note indicated the physician and Assistant Director of Nursing (ADON) were notified. An attempt to reach the resident's legal guardian revealed the guardian's number was disconnected. Record review revealed no written evidence the resident's legal guardian was reached/notified of the resident's transfer to the hospital by facility staff at the time of the transfer. Record review revealed a document titled Transfer/Discharge Notice. The document included the resident's name and listed the date of discharge/transfer as 07/27/24. The reason for discharge/transfer included the resident was discharged to the hospital due to possible self-harm (swallowed batteries times two). The notice was documented to be reviewed by the facility social service director (SSD) and reviewed with the resident. There was no evidence the resident's legal guardian was provided this notice or included in a review of the notice. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed the facility failed to permit Resident #49 to return to the facility following her hospitalization . Interview with the Administrator on 08/10/24 at 11:45 A.M. revealed Resident #49 was transferred to the hospital from the facility on 07/26/24. Resident #49 was then sent from the first hospital to a second hospital for removal of a foreign body following ingestion (that had occurred at the nursing home). During the interview, no additional information was provided to indicate Resident #49's legal guardian had been provided written notice of the resident's transfer to the hospital. This deficiency represents non-compliance investigated under Complaint Number OH00156427.		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on record review and interview the facility failed to provide a written bed-hold notice to Resident #49 and Resident #49's legal guardian at the time of the resident's transfer to the hospital as required. This affected one resident (#49) of three residents reviewed for hospitalization . The facility census was 47. Findings include: Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including unspecified psychosis, post-traumatic stress disorder, Bipolar disorder, schizoaffective disorder, chronic obstructive pulmonary disease, suicide attempts, and intellectual disabilities. Review of admission records revealed this resident had a court appointed guardian, with an effective date of 06/13/22. The resident also had a Medicaid payor source. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had a Brief Interview Mental Status (BIMS) score of ten out of 15 which indicated she had moderate cognitive impairment. Review of a nursing progress note dated 07/26/24 at 9:50 P.M. revealed the resident was sent to the emergency room after confiding in this nurse that she swallowed two AAA batteries. Room checked and found remote on bed without batteries, trash checked, drawers checked. Resident adamant about swallowing batteries. The note indicated the physician and Assistant Director of Nursing (ADON) were notified. An attempt to reach the resident's legal guardian revealed the guardian's number was disconnected. Record review revealed a document titled Transfer/Discharge Notice. The document included the resident's name and listed the date of discharge/transfer as 07/27/24. The reason for discharge/transfer included the resident was discharged to the hospital due to possible self-harm (swallowed batteries times two). The notice was documented to be reviewed by the facility social service director (SSD) and reviewed with the resident. There was no evidence the resident's legal guardian was provided this notice or included in a review of the notice. The notice also contained information related to bed holds including but not limited to: All residents or resident representatives will be notified in regards to the number of bed hold days available for the use of the resident on the first business day following a transfer from the facility. Notification to be completed by the Business Office Manager. Record review revealed no evidence the resident's legal guardian was provided information related to the number of bed hold days the resident had available as required. There was no evidence the legal guardian was provided a written bed hold notice at the time of the resident's transfer or on the first business day following the transfer from the facility as required. Record review revealed the facility failed to permit Resident #49 to return to the facility following her hospitalization . (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 08/10/24 at 11:45 A.M. verified Resident #49's legal guardian was not provided a bed hold notice as required. This deficiency represents non-compliance investigated under Complaint Number OH00156427.		

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on record review, hospital record review and interview, the facility failed to allow Resident #49 to return to the facility upon discharge from the hospital. This affected one resident (#49) of three residents reviewed for hospitalization . The facility census was 47. Findings include: Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including unspecified psychosis, post-traumatic stress disorder, Bipolar disorder, schizoaffective disorder, chronic obstructive pulmonary disease, suicide attempts, and intellectual disabilities. Review of admission records revealed this resident had a court appointed guardian, with an effective date of 06/13/22. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had a Brief Interview Mental Status (BIMS) score of ten out of 15 which indicated she had moderate cognitive impairment. Review of a nursing progress note dated 07/26/24 at 9:50 P.M. revealed the resident was sent to the emergency room after confiding in this nurse that she swallowed two AAA batteries. Room checked and found remote on bed without batteries, trash checked, drawers checked. Resident adamant about swallowing batteries. The note indicated the physician and Assistant Director of Nursing (ADON) were notified. An attempt to reach the resident's legal guardian revealed the guardian's number was disconnected. A nursing progress note dated 07/29/24 at 4:04 A.M. revealed resident had batteries removed via scope. Nurse stated she should be returning back to the facility today. Record review revealed no additional progress notes related to why the resident did not return to the facility as planned/noted in the above note on 07/29/24. Interview with Licensed Practical Nurse #20 on 08/10/24 at 11:20 A.M. revealed Resident #49 was residing in the facility until 07/26/24. The resident was transferred to the hospital emergency room due to an acute change in condition with concerns related to the resident ingesting batteries. Interview with Licensed Practical Nurse #10 on 08/10/24 at 11:30 A.M. revealed Resident #49 was sent to the hospital and did not return. (continued on next page)		

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 08/10/24 at 11:45 A.M. revealed Resident #49 was transferred to the hospital from the facility on 07/26/24. Resident #49 was then sent from the first hospital to a second hospital for removal of a foreign body following ingestion (that had occurred at the nursing home). The Administrator stated the second hospital allowed Resident #49 to leave their facility against medical advice (AMA) and she went out in the community. The Administrator stated after the resident left the hospital AMA and was out in the community, he believed they did not have to take her back. During the interview, the Administrator verbalized awareness of the resident being taken back to the hospital/emergency room after she left the second hospital AMA due to concerns of her ingesting another substance at a local store. Review of hospital medical record documentation, dated 07/31/24 at 12:15 P.M. and completed by case management staff revealed the case manager/social worker was advised the resident was in the emergency department (ED) and the facility was refusing to accept her back. The note indicated the resident had a legal guardian. The note revealed the social worker was advised the resident had been in the ED earlier in the week and was transferred to another hospital (name provided of second hospital). While she was at this other hospital, she was allowed to sign out against medical advice (AMA) despite having a legal guardian. The resident found a ride and emergency medical services were subsequently called to a Walmart the resident was at as she (the resident) reported to someone there she had taken a bottle of Benadryl. After receiving treatment in the ED, hospital staff contacted the nursing home to advise them that due to the resident not having the capacity to sign herself out AMA, she was still their resident. The Administrator indicated he refused to allow the resident to return, stating she was a community member and not their problem. The Administrator confirmed the resident had resided in the facility for approximately two months prior to being transferred to the hospital for acute medical care (after swallowing batteries). The hospital medical record included the Administrator advised he wasn't taking the resident back, it didn't matter what was said. Hospital staff informed the Administrator he would be required to issue the resident a 30 day discharge notice, which the Administrator stated he did not. The hospital staff involved with the situation indicated the Ombudsman would be notified and the Administrator indicated he did not care and then he abruptly ended the call. On 07/31/24 at 2:26 P.M. the case manager/social worker spoke with the discharge planner at the other hospital involved with resident's care. The discharge planner revealed Resident #49 had received care, was stabilized, ready for discharge back to the nursing home and she had communicated this to the nursing home (date not provided). The discharge planner had started the prior authorization process for the resident to return and were only waiting on an occupational therapy (OT) evaluation. The discharge planner revealed she was unaware the resident was tired of waiting so the staff inappropriately allowed her to sign an AMA. On 07/31/24 at approximately 3:53 P.M. hospital staff reached out the facility medical director to discuss the situation with him including the facility was refusing to allow Resident #49 to return. The note indicated the medical director stated he could see both views on the situation and he'd call the NH Administrator to reconsider. The medical director text back shortly thereafter advising the administrator would not reconsider. (continued on next page)		

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 4:24 P.M. the hospital case manager/social worker spoke with the Ombudsman regarding the situation and refusal of the facility to allow the resident to return. The note indicated the Ombudsman was also in agreement that refusing to allow the resident to return was a violation of her rights and indicated she would reach out to the facility to let them know they would have to accept the resident back. Continued review of hospital notes from 08/01/24 indicated hospital staff were actively working on trying to find a new discharge location that was appropriate for the resident as the facility continued to refuse to allow her to return. A note dated 08/01/24 at 3:43 P.M. revealed staff at the facility had been instructed not to talk to anyone calling from the hospital regarding Resident #49 and that they would have to speak to the Administrator. Hospital staff had reached out to the facility in an attempt to get a copy of the resident's Pre-Admission Screening and Resident Review (PASRR) documents. Hospital discharge planning continued on 08/02/24 for the resident who had been ready to discharge back to the facility on [DATE]. The resident was ultimately discharged from the hospital to an appropriate facility for ongoing care and treatment post hospitalization . This deficiency represents non-compliance investigated under Complaint Number OH00156427.		