

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

Printed: 03/27/2025
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 01/16/2025
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on record review, interview and policy review, the facility failed to ensure residents were free from abuse. This resulted in an Actual Harm when Resident #12 was assaulted by Resident #39 on 01/11/25. Resident #12 was punched in the face and was temporarily unconscious. Resident #12 was evaluated at the local hospital, diagnosed with mild closed head injury, lip abrasion, and cervical strain. This affected one (Resident #12) of three residents reviewed for abuse. The facility census was 47. Findings include: Review of the medical record for Resident #12 revealed an admitted on 03/22/24. Diagnoses included intracranial injury with loss of consciousness on 06/29/23, major depressive disorder, dementia, personality disorder, generalized anxiety disorder, borderline personality disorder, bipolar two disorder, and post-traumatic stress disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/14/24, revealed that Resident #12 was cognitively intact. Resident #12 used a wheelchair to self-propel in the facility. Review of medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included unspecified focal traumatic brain injury without loss of consciousness, paranoid schizophrenia, epilepsy, hemiplegia, panic disorder, extrapyramidal and movement disorder, Schizoaffective disorder depressive type, pseudobulbar affect, general anxiety disorder, attention deficit hyperactivity disorder, psychotic disorders with delusions due to known physiological condition, auditory hallucinations, visual hallucinations (09/08/22), suicidal ideations (09/08/22), homicidal ideations (09/22/22), and post-traumatic stress disorder chronic (09/08/22). Review of the quarterly MDS assessment, dated 12/24/24, revealed Resident #39 was cognitively intact. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the plan of care dated 12/24/24 revealed that Resident #39 had behaviors and problems related to profanity, fabricating stories, angry verbal outbursts towards others, spitting on staff, throwing things at staff, refusing care, aggression towards others, attention seeking, stating that he had been misdiagnosed , physical behaviors towards inanimate objects, kicking things, refuse vitals, inappropriate sexual behaviors towards staff, resident referred to therapy multiple times related to falls, history of refusals to medication and physical assessments, and requesting more anxiety medications. Interventions included one on one at times of agitation, administer medications, provide risks and benefits during refusals of care, intervention due to physical outburst on 01/01/23 to 01/02/23 shift, monitor and assess for behaviors, physical outbursts over shower times that he agrees upon then suddenly changes his mind, provide a calm and relaxing environment, refer to psych, and resident was educated to ask for assistance when he was in a difficult situation. Resident #39 used a wheelchair to self-propel in the facility. Further review of the plan of care dated 12/24/24 revealed Resident #39 was at risk for alteration in cognitive function related to anxiety, depression, traumatic brain injury, paranoid schizophrenia, panic disorder, schizoaffective disorder, pseudobulbar affect, ADHD, psychotic disorder, hallucinations, delusions, and post-traumatic stress disorder. Interventions included allow resident time to remember and respond, be as consistent as possible with daily routine, be patient with resident, continue to converse and communicate with resident daily despite cognitive deficits, ensure resident's physiological needs are met, formulate plan for hospital admission if condition warrants, medication as ordered, provide a calm and relaxing environment, provide activities of choice, repeat directions as needed, report any changes to physician, and speech therapy as ordered. Review of a progress note dated 01/11/25 by Registered Nurse (RN) #290 documented Resident #12 and Resident #39 were in a verbal exchange as they were outside for a smoke break. Resident #39 called Resident #12 names, and Resident #12 told him to shut up. Resident #39 swung at Resident #12. Resident #12 swung her arm sideways to keep from being hit. Resident #39 wheeled himself to get in front of her and connected with her face again. Resident #39 continued to curse at Resident #12. Resident #39 stated he didn't care if it was female, male or child he would hit whomever he felt needed it. Resident #12 was removed from the smoking patio and immediately taken with staff to the nursing station and was supervised through the rest of the night. RN #290 stated she notified the physician and responsible party. Review of the local police incident report dated 01/11/25 at 7:26 P.M. documented Resident #39 was the suspect who was being investigated for disorderly conduct. Residents were fighting and one resident had possibly been assaulted. Resident #12 had suffered minor injuries. Currently still under investigation. Review of a skin assessment dated [DATE] revealed Resident #12 had an abrasion to the upper inner lip measuring 0.2 centimeter (cm) by 0.1 cm and a purplish area to the lower inner lip. Resident #12 had scant amount of bleeding and a cool wet cloth was applied to the area. Resident #12's teeth were intact. There was redness to the upper right cheek and no bruising. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a hospital document dated 01/11/25 revealed Resident #12 was sent to the hospital to be evaluated after another resident (Resident #39) struck her in the right side of the face with a fist. Resident #12 was diagnosed with assault with minor closed head injury, lip abrasion, and cervical strain. She had perhaps lost consciousness for two minutes. She was alert and oriented to her name and place and situation. She admits to some discomfort in her mouth where it appears that she had an abrasion to her right upper lip. She complains of discomfort to the right side of her head but had no bruising. She was positive for neck pain. A Computed Tomography (CT) scan to head demonstrated no evidence of midline shift mass effect, acute bleeding, fracture, or hematoma. Resident #12 seems to be back to her baseline at this point. She was alert and knew where she was at. Resident #12 remembered the event that resulted in her being struck to the face. Discussed the case with the Medical Director, who returned Resident #12 to the facility with an order for neurological checks every four hours for 24-hours. During an interview on 01/14/25 at 3:21 P.M., RN #290 stated Resident #12 was hit by Resident #39, and she was standing behind them. RN #290 stated Resident #39 was cursing and yelling at staff to be on the smoke break on time. RN #290 stated they were getting residents out the smoke patio door when a verbal altercation between Resident #12 and Resident #39 broke out. Resident #12 had tried to stand up for staff in saying they were busy and was only a few minutes short in getting a timely smoke break. RN #290 stated that Resident #12 threw an arm up to block Resident #39 from hitting her, and was struck in the face by his hand. RN #290 was coming from behind her to break Resident #39 from hitting Resident #12. Resident #39 hit Resident #12 a second time in the face, and she went slumped over unconscious in her wheelchair. RN #290 got to Resident #12 to support her limp body to make sure she was safe. RN #290 stated she directed Resident #39 to another part of the smoke patio. RN #290 stated Resident #39 was calling Resident #12 a faker, and stating he would hit any woman, man, or child if need be. Resident #12 was unconscious for a few seconds because yelling her name did not arouse here. Resident #12 woke up as they were getting her inside the building. Her bottom lip was purple and bleeding. Resident #12 repeated he hit me. RN #290 stated Resident #12 went to the emergency room to be assessed. RN #290 stated to the physician she thought Resident #12 was knocked out. During an interview on 01/14/25 at 5:34 P.M., STNA #237 stated she ran to Resident #12 and saw her eyes closed and she was slumped over in the wheelchair. Resident #39 was yelling on the other side of the patio, saying she was faking. She was moved back in the facility, and startled and started to cry, and was upset. She was taken to the nursing station. Review of facility policy titled Abuse Prohibition dated unknown stated that residents will not be subjected to abuse, neglect, exploitation, mistreatment, or misappropriation of property by anyone. This deficiency represents non-compliance investigated under Complaint Number OH00161543.		