

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

Printed: 02/11/2025
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 12/12/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to ensure a resident's dignity was maintained by placing a cover over a urinary catheter drainage bag. This affected one (#28) of three residents the facility identified as having indwelling urinary catheters. The facility census was 44. Findings include: Record review for Resident #28 revealed the resident was admitted to the facility on [DATE] and had diagnoses including muscle weakness, neuromuscular dysfunction, and spastic diplegic cerebral palsy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was assessed to have intact cognition and to have an indwelling urinary (Foley) catheter. Review of an active physician order dated 10/03/24 reveled Resident #28 was to have a 16 French Foley catheter in place. Observation on 12/09/24 at 12:40 P.M. revealed Resident #28 was lying in bed with the door open. The resident's Foley catheter drainage bag was hanging on the side of the bed visible from the doorway. No dignity bag was in place over the bag and yellow urine was visible in the tubing and drainage bag. Observation on 12/10/24 at 12:55 P.M. revealed Resident #28 was lying in bed with the door open. The resident's Foley catheter drainage bag was hanging on the side of the bed visible from the doorway. No dignity bag was in place over the bag and yellow urine was visible in the tubing and drainage bag. Observation on 12/11/24 at 9:30 A.M. revealed Resident #28 was lying in bed with the door open. The resident's Foley catheter drainage bag was hanging on the side of the bed visible from the doorway. No dignity bag was in place over the bag and yellow urine was visible in the tubing and drainage bag. Interview with Activity Director #118 at the time of the observation confirmed there was not a dignity bag in place but there should have been. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on medical record review and staff interview, the facility failed notify a physician of resident blood glucose levels when the level was above 400 milligrams per deciliter (mg/dL) as ordered. This affected one (#20) of five residents reviewed for unnecessary medications. The facility census was 44. Findings include: Review of Resident #20's medical record revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, unspecified severe protein calorie malnutrition, respiratory failure, major depressive disorder, generalized anxiety disorder, and dysphagia. Review of Resident #20's physician order dated 03/29/24 revealed the resident was ordered Humalog Kwikpen subcutaneous (SQ) solution pen-injector 100 unit/ml to be injected as per sliding scale before meals and at bed time for diabetes as followed: for blood glucose levels between zero (0) and 149 mg/dL, notify the physician and administer no insulin; between 150 mg/dL and 199 mg/dL, give two (2) units of insulin; between 200 mg/dL and 249 mg/dL, give four (4) units of insulin; between 250 mg/dL and 299 mg/dL, give six (6) units of insulin; between 300 mg/dL and 349 mg/dL, give eight (8) units of insulin; between 350 mg/dL and 399 mg/dL, give 10 units of insulin; and blood glucose levels above 400 mg/dL, give 12 units of insulin and notify the physician. Further review of Resident #20's medical record revealed from 11/10/24 to 12/09/24 Resident #20's blood glucose was over 400 mg/dL 12 times and the physician was only notified on four occasions. The physician was not notified on 11/12/24 with a blood glucose level of 432 mg/dL, 11/15/24 with a blood glucose level of 500 mg/dL, on 11/17/24 with a blood glucose levels of 408 mg/dL and 426 mg/dL, on 11/21/24 with a blood glucose level of 567 mg/dL, 11/22/24 with a blood glucose level of 498 mg/dL, 11/25/24 with a blood glucose level of 520 mg/dL, 11/27/24 with a blood glucose level of 450 mg/dL, on 11/28/24 with a blood glucose level of 411 mg/dL, on 12/02/24 with a blood glucose level of 418 mg/dL, on 12/04/24 with a blood glucose level of 488 mg/dL, and on 12/05/24 with a blood glucose levels of 511 mg/dL. Interview with Regional Nurse #200 on 12/12/24 at 10:20 A.M. verified Resident #20's blood glucose level was above 400 mg/dL on 11/12/24, 11/15/24, 11/17/24, 11/21/24, 11/22/24, 11/25/24, 11/27/24, 11/28/24, 12/02/24, 12/04/24, and 12/05/24 and the physician was not notified as ordered.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review and staff interview, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) after receiving Medicare Part A services at the facility as required. This affected three (#04, #28, and #40) of three residents reviewed. The facility census 44. Findings include: 1. Record review for Resident #04 revealed the resident admitted to the facility on [DATE]. Diagnoses included diabetes mellitus, essential primary hypertension, schizoaffective disorder, major depressive disorder, anxiety disorder, and schizophrenia. Review of Resident #04's Minimum Data Set (MDS) assessment dated [DATE] revealed she was mildly cognitively impaired. Review of Resident #04's Medicare cut letter dated 09/20/24 revealed she was cut for Medicare skilled services effective 09/23/24; however, the facility failed to provide Resident #04 a SNF ABN. 2. Record review for Resident #28 revealed the resident admitted to facility on 11/28/24. Diagnoses included urinary tract infection, asthma, aphasia, dysarthria, dysphasia, anemia, anxiety disorder, and major depressive disorder. Review of Resident #28's MDS assessment dated [DATE] revealed she was mildly cognitively impaired. Review of Resident #28's Medicare cut letter dated 11/05/24 revealed she was cut from Medicare skilled services effective 11/07/24; however, the facility failed to provide Resident #28 a SNF ABN. 3. Record review for Resident #40 revealed the resident admitted to the facility on [DATE]. Diagnoses included hyperlipidemia, peripheral vascular disease, dementia, adjustment disorder, essential primary hypertension, insomnia, and anxiety disorder. Review of Resident #40's MDS assessment dated [DATE] revealed he was cognitively impaired. Review of the Resident # 40's Medicare cut letter dated 12/04/24 revealed he was cut from Medicare skilled services, effective 12/06/24; however, the facility failed to provide Resident #40 a SNF ABN. Interview on 12/12/24 at 10:04 A.M. with Regional Nurse (RN) #200 confirmed Resident #04, Resident #28, and Resident #40 remained in the facility after their Medicare skilled services were cut and the facility failed to provide each resident a SNF ABN as required.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review and staff interview, the facility failed to complete a Significant Change in Status Assessment for a resident enrolled in a hospice program. This affected one (#44) of three residents reviewed for Minimum Data Set assessments. The facility census was 44. Findings include: Record review for Resident #44 revealed the resident admitted to the facility on [DATE]. Diagnoses included dyskinesia, psychosis, essential primary hypertension, dementia, carbuncle, gout, depression, and adult failure to thrive. Review of Resident #44's progress notes dated 09/04/24 revealed the facility called to notify Resident #44's family of a change in condition. Further review of the progress notes confirmed Resident #44 was admitted to hospice services effective 09/12/24. Review of Resident #44's contract for hospice confirmed hospice services were effective on 09/12/24. Further review of Resident #44's medical record revealed no Significant Change in Status Minimum Data Set (MDS) assessment was completed when the resident received hospice services. Interview with MDS Licensed Practical Nurse (LPN) #134 confirmed Resident #44 was under hospice care effective 09/12/24 and remained on hospice until Resident #44's death at the facility on 10/27/24. MDS LPN #134 confirmed the facility failed to complete a Significant Change in Status MDS assessment for Resident #44 and state the assessment should have been completed within 14 days of hospice enrollment.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff interview and medical record review, the facility failed to to ensure Pre-Admission Screening and Resident Review (PASARR) documents were accurate regarding resident current conditions and diagnoses. This affected two (#23 and #27) of two residents reviewed for PASARR documents. The census was 44. Findings include: 1. Review of Resident #27's medical record revealed an admitted [DATE]. Diagnoses included nephropathy induced by other drugs, type two diabetes mellitus with diabetic neuropathy, cellulitis, adult failure to thrive, hyperlipidemia, gout due to renal impairment, anxiety disorder, and bipolar disorder manic without psychotic features. Review of Resident #27's medical record revealed on 05/15/24 the resident had a new diagnosis of bipolar disorder manic without psychotic features. Review of Resident #27's most current PASARR dated 09/08/23 revealed there was no updated diagnosis of bipolar disorder manic without psychotic features. Interview with Regional Nurse #200 on 12/12/24 at 12:39 P.M. verified there was not an updated diagnosis of bipolar disorder manic without psychotic features on Resident #27's most recent PASARR, and an updated PASARR should of been completed with the new diagnosis. 42728 2. Record review for Resident #23 revealed the resident was admitted to the facility on [DATE] and had diagnoses including anxiety disorder, senile degeneration of the brain, and dissociative identity disorder. The resident had a new diagnosis of schizoaffective disorder added on 11/14/23. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was rarely/never understood. Review of the completed PASARR assessments for Resident #23 revealed no updated PASARR was completed after the addition of the diagnosis of schizoaffective disorder was added on 11/14/23. Interview with Regional Nurse #200 on 12/11/24 at 3:15 P.M. confirmed a new PASARR assessment was not completed for Resident #23 following the addition of a new mental health diagnosis.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 31404 Based on medical record review and staff interview, the facility failed develop a plan of care to address a resident's post traumatic stress disorder. This affected one (#31) of one residents reviewed for behavior and emotional needs. The facility identified five residents with a diagnosis of post traumatic stress disorder. The facility census was 44. Findings include: Review of Resident #31's medical record revealed an admitted [DATE] with diagnoses including traumatic brain injury, paranoid schizophrenia, hemiplegia affecting the left non-dominant side, psychotic disorder with delusions, auditory and visual hallucinations, suicidal ideations, paranoid personality disorder, major depressive disorder, hereditary and idiopathic neuropathy, post traumatic stress disorder, homicidal ideations, edema, and hyperlipidemia. Review of the 11/08/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #31 was cognitively intact and used a wheelchair to aid in mobility. The resident was coded as having a diagnosis of post traumatic stress disorder (PTSD). Further review of Resident #31's medical record on 12/10/24 revealed there was no care plan to address the resident's PTSD and identified triggers. Interview with Regional Nurse #200 on 12/10/24 at 3:37 P.M. verified Resident #31 did not have a care plan for PTSD that identified triggers.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 31404 Based on observation, review of dietary menus, and staff interview, the facility failed to serve all food items from the preplanned menu during meal service. This had the potential to affect all 44 residents in the facility. The census was 44. Findings include: Review of the dietary menu for week one, which contained the date of 12/11/24, revealed the meal was to include spaghetti sauce with meatballs, pasta, green beans, wheat bread, margarine, and cake. Observation on 12/11/24 at 11:32 P.M. revealed the cook was preparing the meals which included spaghetti sauce with meatballs, pasta, green beans, and cake. Further observation revealed the cook was not serving bread with the meals as indicated on the menu. Interview with Dietary Manager (DM) #167 on 12/11/24 at 2:07 P.M. verified the menu for 12/11/24 was to have wheat bread included with the meal and confirmed the facility did not serve bread on the lunch trays. DM #167 stated they just forgot to add the bread to the meal trays.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 31404 Based on review of Quality Assurance and Performance Improvement (QAPI) staff sign-in sheets and staff interview, the facility failed to have QAPI meetings at least quarterly and failed to have all required members in attendance. This had the potential to affect all 44 residents in the facility. The census was 44. Findings include: Review of the QAPI meeting sign-in sheet dated 01/11/24 revealed the facility's administrator, owner, board member, or other individual in a leadership role was not in attendance for this meeting. Further review of the QAPI sign-in sheets revealed a meeting was held 03/12/24 and the next meeting was not held until 08/22/24. There was no documentation of a second quarter (April, May, or June) QAPI meeting occurring in 2024. Interview with the Administrator on 12/12/24 at 1:40 P.M. verified the facility did not have the administrator, owner, board member, or other individual in a leadership role attend the QAPI meeting on 01/11/24. The Administrator also verified the facility did not hold QAPI meetings at least quarterly as the facility had a meeting on 03/12/24 and did not have another meeting until 08/22/24.		