

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365945	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Mansfie		STREET ADDRESS, CITY, STATE, ZIP CODE 1159 Wyandotte Ave Mansfield, OH 44906	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, review of infection control documents, staff interview, review of Centers for Disease Control and Prevention (CDC) guidance, and review of the facility policy, the facility failed to ensure resident infections were adequately tracked for potential trends, failed to ensure residents who required Enhanced Barrier Precautions (EBP) had signage in place to including instructions for use of specific personal protection equipment (PPE), failed to ensure staff wore PPE during high-contact resident care activities with residents in EBP, and failed to ensure indwelling catheters were stored appropriately. This affected Residents #1, #6, and #49 and had the potential to affect all 60 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date on 06/07/23. Diagnoses included paraplegia, chronic kidney disease, and cholecystitis. Review of the care plan dated 05/25/26 revealed Resident #1 had alteration in elimination due to having an indwelling urinary catheter from urinary retention and neurogenic bladder. Interventions included monitoring for signs and symptoms of urinary tract infection (UTI), and indwelling urinary catheter care every shift and as needed. Review of the entry Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was cognitively intact and had a indwelling catheter. The care plan dated 06/23/26 revealed Resident #1 had an area of concern to the left heel. Interventions included monitoring for signs and symptoms of infection. The care plan dated 06/28/26 revealed Resident #1 required EBP due to a chronic wound and indwelling urinary catheter use. Interventions included using PPE in conjunction with standard precautions which included using gown and gloves during high contact resident care activities. Review of the physician's orders revealed on 06/24/26, an order for right foot apply dry sterile dressing and kerlix with ace wrap everyday use [NAME] heel for protection in the morning every other day for right foot ulcer. On 06/20/26, an order for left heel cleanse with normal saline, apply xeroform dry sterile dressing, kerlix and ace wrap every day in the morning. There were no physician orders for Resident #1 to be on EBP. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 06/28/26 at 8:53 A.M. revealed Resident #1 sitting in his wheelchair. Resident #1's catheter bag was underneath of the wheelchair touching the floor. Licensed Practical Nurse (LPN) #378 confirmed the catheter bag was on the ground and confirmed the catheter bag should off of the floor to prevent infection. Observation on 06/28/26 at 9:00 A.M. of Resident #1's room revealed there were no signs for EBP posted on the door or PPE outside of the room. Interview on 06/28/26 at 9:45 A.M. with Licensed Practical Nurse (LPN) #378 confirmed Resident #1 did not have a sign on the door for EBP and confirmed there was no order for EBP. 2. Review of the medical record for Resident #6 revealed an admission on [DATE]. Diagnoses included chronic metabolic acidosis, and hydronephrosis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 was cognitively intact and was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 06/05/26 revealed Resident #6 required EBP due to indwelling urinary catheter and wound to right heel. Interventions included using PPE in conjunction with standard precautions of using a gown and gloves during high contact resident care activities. Review of the physician's orders revealed on 06/09/26, an order for indwelling urinary catheter to continuous drain every shift related to obstructive and reflux uropathy. On 05/29/26, there was a treatment in place for Resident #6's right heel treatment. There were no physician orders for Resident #6 to be on EBP. Observation on 06/28/26 at 9:32 A.M. revealed Certified Nursing Assistant (CNA) #402 entered into Resident #6's bedroom without any PPE on. Interview on 06/28/26 at 9:40 A.M. with CNA #402 revealed Resident #6 had a bowel movement on the bedpan and required assistance with care. Resident #6 confirmed PPE was not worn during care. 3. Review of the medical record for Resident #49 revealed an admission on [DATE]. Diagnoses included overactive bladder, dysuria, and anemia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was cognitively intact. Review of the care plan dated 05/05/26 revealed Resident #49 had an alteration in elimination by indwelling urinary catheter. Interventions included catheter care every shift and as needed. There was no care plan for Resident #49 to be in EBP. Review of the physician's orders dated 06/08/26 revealed an order for indwelling urinary catheter to continuously drain every shift for urinary retention. There were no physician orders for Resident #49 to be on EBP. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 06/28/26 at 9:14 A.M. of Resident #49's bedroom revealed no sign on the door for EBP. Interview on 06/28/26 at 9:45 A.M. with Licensed Practical Nurse (LPN) #378 confirmed Resident #49 did not have a sign for EBP and did not have a physician order or care plan for EBP. Review of the CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP is an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status. 4. Review of the facilities infection surveillance on 06/29/26 at 1:30 P.M. revealed there was no monitoring of trends in infections from 01/01/26 through 06/29/26. Interview on 06/29/26 at 1:45 P.M. with Registered Nurse (RN) #345 who was the facilities Infection Preventionist (IP) revealed she was not aware she had to track infections that did not meet McGreer's criteria and confirmed there was no tracking of trends in infections. Review of the CDC guidance titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated 04/12/24 and found at https://www.cdc.gov/infection-control/hcp/core-practices/index.html revealed under Performance Monitoring Feedback, a core practice included to monitor the incidence of infections that may be related to care provided at the facility and act on the date and use information collected through surveillance to detect transmission of infectious agents in the facility.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, observation and policy review, the facility failed to ensure residents dependent on staff for activities of daily living (ADL) received adequate nail care and personal hygiene assistance. This affected two residents (#5 and #43) of three residents reviewed for ADL care. The facility census was 60. Findings include: 1. Review of Resident #5's medical record revealed an admission date of 04/21/20. Diagnoses included anxiety disorder, diabetes mellitus (DM), and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had severely impaired cognition and was dependent on staff with personal hygiene. Review of the care plan dated 05/07/26 revealed Resident #5 had DM with an intervention to refer to the podiatrist or foot care nurse to monitor foot care needs and to cut long nails. Resident #5 had an ADL self-care performance deficit with and intervention to inspect Resident #5's skin weekly and to observe for redness, open areas, scratches, cuts, and to report changes to the nurse. Review of Resident #5's shower sheets for the months of May 2026 and June 2026 revealed the last time Resident #5's nails were documented to be cleaned and trimmed was on 05/26/26. Observation on 06/28/26 at 9:23 A.M. revealed Resident #5's fingernails on his left hand were long. Due to the contracture of his left hand, Resident #5's fingernails were digging into the palm of his hand. Interview on 06/30/26 at 8:33 A.M. with Certified Nurse Aide (CNA) #398 verified Resident #5's fingernails on his left hand were long and digging into his palm. CNA #398 stated Resident #5 had DM and required the nurse to cut his fingernails. Review of the undated facility policy titled Resident Nail Care revealed the facility shall provide routine nail care as necessary to maintain resident comfort, hygiene, and skin integrity while ensuring services are provided safely and within each staff members scope of practice. 2. Review of Resident #43's medical record revealed an admission date of 11/13/23. Diagnoses included dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 had severely impaired cognition and required supervision or touching assistance from staff with personal hygiene. Review of Resident #43's care plan dated 05/15/26 revealed Resident #43 was at risk for Activities of Daily Living (ADL) decline with interventions that included to encourage resident participation while performing ADLs and to try to make the ADL routine consistent to foster recognition of necessary tasks. Observations on 06/28/26 at 8:31 A.M. and 06/29/26 at 8:31 A.M. revealed Resident #43 who was a female had facial hair surrounding her mouth. Interview on 06/29/26 at 4:07 P.M. with Activities Assistant #343 verified Resident #43 still had facial hair surrounding her mouth. Review of the undated facility policy titled Resident Dignity revealed staff would provide care that preserves each resident's dignity by maintaining the resident's personal appearance and hygiene consistent with their preferences and care plan.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, the facility failed to ensure insulin medications were labeled appropriately with a date when opened and resident's names were on the medication, and medications were not left at a resident's bedside. This affected two of six medication carts observed for medication storage and the facility identified there were six medication carts in the facility. This affected Residents #32, #57, and #64. The census was 60. Findings Include: 1. Observation on 06/29/26 at 7:41 A.M. of the 100-Hall A medication cart revealed an insulin Novolin R solution multi-dose vial 100 unit per milliliter (ml) with a dispense date from the pharmacy on 05/30/25 was not dated when opened for Resident #57. a Novolin R injection pen 100 units dispensed from pharmacy on 03/08/26 was not dated when opened for Resident #57, and a multi-dose vial of Lantus 100 units per ml dispensed from pharmacy on 03/08/26 was not dated when opened. Interview on 06/29/26 at 7:48 A.M. with Registered Nurse (RN) #399 verified the three insulin pens were not dated when opened and should be discarded after 28 days. 2. Observation on 06/29/26 at 7:50 A.M. of the 300-Hall medication cart revealed Lispro Kwik Pen injection dispensed from pharmacy on 10/20/25 was not dated when opened for Resident #32, Novolog 100 unit per milliliter (ml) multi-dose vial dispensed from pharmacy on 05/05/26 was not dated when opened and did not have a resident's name on it, and Lispro kwik pen injection was not dated when opened and did not have a resident's name on it. Interview on 06/29/26 at 7:59 A.M. with Licensed Practical Nurse (LPN) #359 verified three insulins were not dated when opened. LPN #359 stated she believed the NovoLog was being used for Resident #57 and the Lispro insulin that did not have a name on it was for Resident #32. Review of the Insulin reference chart on the medication cart from pharmacy revealed Novolin R solution, Lantus 100 units per ml and Lispro Kwik Pen injection should be discarded when not in the refrigerator for 28 days. 3. Review of the medical record for Resident #64 revealed an admission on [DATE]. Diagnoses included depression, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 was cognitively intact. Review of the care plan dated 03/19/26 revealed Resident #64 did not have a focus area stating Resident #64 can self-administer medication. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders revealed no order for Resident #64 to self-administer medication, or leaving medications at bedside. Observation and interview on 06/28/26 at 8:25 A.M. revealed Resident #64 had a cup of unknown pills with Resident #64's name on them sitting on her bedside table. Resident #64 revealed the medications on the bedside table were her morning medications. Resident #64 stated the staff trust her to take her medications. Interview on 06/28/26 at 8:35 A.M. with Licensed Practical Nurse (LPN) #378 confirmed the medications on Resident #64's bedside table were the morning medications. LPN #378 confirmed Resident #64 did not have an order to leave medications at bedside. LPN #378 stated Resident #64 was reliable, so she thought it was ok to leave medications with her. Review of the facility's undated policy titled Medication Management revealed medications will be checked for expiration dates, and expired drugs will be pulled at least once a month. Medication carts must be used for storage of all medications managed by the community.		

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review, policy review, and staff interview, the facility failed to implement their policy by ensuring all employees were screened in the Ohio Nurse Aide Registry (NAR) prior to or on their first day of work/hire to ensure the employee did not have a finding entered into the NAR concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property as required. This had the potential to affect all 60 residents residing in the facility. Findings include: 1. Review of the personnel file for the Licensed Nursing Home Administrator (LNHA) revealed a hire date of 01/06/26. There was no evidence of the LNHA being screened in the NAR. 2. Review of the personnel file for Dietary Aide (DA) #310 revealed a hire date of 03/12/26. There was no evidence of DA #310 being screened in the NAR. 3. Review of the personnel file for Registered Nurse (RN) #399 revealed a hire date of 10/27/25. There was no evidence of RN #399 being screened in the NAR. Interview on 06/29/26 at 11:25 A.M. with Human Resource Manager (HR) #377 verified the LNHA, DA #310, and RN #399 were not screened in Ohio's NAR. HR #377 stated she only screened the certified nursing aides (CNAs) in Ohio's NAR. Review of the facility's policy dated 04/29/26 titled Resident Abuse, Neglect, Exploitation and Misappropriation of Property, revealed all individuals applying for employment at (the facility) are screened through an interview process which includes questions about convictions, a thorough check of references and contact with the State's Nurses Aide Registry or other appropriate licensing board.		