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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366002 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/03/2024 |
| NAME OF PROVIDER OR SUPPLIER Crestline Rehabilitation and Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 327 West Main Street Crestline, OH 44827 | |

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) |
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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>16453</p> <p>Based on observation, medical record review, resident and staff interview, and facility policy review, the facility failed to ensure medications were not left unattended and unsecured in resident rooms. This affected one (#2) of three resident rooms observed. The facility census was 22.</p> <p>Findings include:</p> <p>Review of Resident #2's medical record identified her admission to the facility occurred on 12/19/20 with medical diagnosis including malnutrition, depression, pancreatic tumor, and esophageal stricture. The most recent comprehensive assessment completed on 03/04/24 identified Resident #2 was completely cognitively intact.</p> <p>Observation and interview with Resident #2 on 05/03/24 at 10:41 A.M. revealed a full cup of oral medications sitting on the resident's bedside stand with a cup of pudding. Interview with Resident #2 at that time confirmed the nursing staff usually set her medications down and leave them with her, and stated sometimes she just throws them in the trash.</p> <p>Review of Resident #2's medication administration record (MAR) for May 2024 revealed the residents morning medications for 05/03/24 were signed off as administered even though they were observed sitting on her bedside table and had not consumed them.</p> <p>Observation and interview with the Director of Nursing (DON) on 05/03/24 at 10:50 A.M. revealed Resident #2's oral medications sitting on her bedside stand. The DON confirmed the medication sitting on Resident #2's bedside stand at that time and stated no medications should be left in resident rooms unattended.</p> <p>Review of the facility policy titled, Administering Medications, dated December 2012, revealed the individual administering the medications must initial the medication administration record (MAR) on the appropriate line after giving the resident the medication and before administering the next one.</p> <p>This deficiency was based on an incidental finding discovered during the course of complaint investigation.</p> |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>16453</p> <p>Based on observation, review of facility menus, and staff interview, the facility failed to ensure menus were followed. This affected all 19 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13, #14, #15, #16, #17, #18, #19, and #22) residents who the facility identified as receiving meals from the kitchen. The facility census is 22.</p> <p>Findings include:</p> <p>Review of the lunch menu for Friday, 05/03/24, identified baked fish, macaroni and cheese, creamy coleslaw, bread and butter, and Jello poke cake were planned to be served.</p> <p>Observation of the kitchen meal service on 05/03/24 at 11:50 A.M. revealed Cook #5 was observed to plate resident meals with fish, macaroni and cheese, creamy coleslaw, and Jello. The observation identified meal cart #1 left the kitchen on 05/03/24 at 12:00 P.M. and none of the trays included bread and butter as listed on the menu.</p> <p>Interview with Cooperate Dietary Manager #10 was completed on 05/03/24 at 12:05 P.M. in the hallway as the staff started delivering meal trays to the residents. Corporate Dietary Manager #10 confirmed the meal trays did not include bread and butter as per the menu. The interview confirmed Cook #5 did not follow the dietician approved menus by not serving the bread and butter.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153014.</p> | | |