STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366002	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestline Rehabilitation and Nursing Center	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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure enteral tube feeding was administered per physician orders. This affected one (#22) of three residents reviewed for enteral tube feeding. The facility identified three residents not receiving any food by mouth and on enteral tube feeding. The facility census was 21.Findings include: Review of Resident #22's medical record revealed an admission date of 12/16/25 and a discharge date of 02/20/26. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, type two diabetes mellitus without complications, peripheral vascular disease, squamous cell carcinoma of the skin, heart failure, cerebral infarction, and persistent vegetative state.Review of Resident #22's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was comatose. Furthermore, Resident #22 received nothing by mouth, had a gastrostomy tube (G-tube) and required enteral feeding for nutrition.Review of Resident #22's care plan dated 12/17/25 and revised 02/13/26 revealed the resident required a tube feeding related to dysphagia, persistent vegetative state, cerebral vascular accident (CVA), and nothing by mouth (NPO) status. Interventions included to administer enteral feedings and fluids via the feeding tube as ordered, keep head of bed elevated 45 degrees while administering tube feed and 30 minutes after the administration of the tube feeding, check for tube placement and gastric contents/residual per facility protocol and record, Registered Dietitian (RD) to evaluate quarterly and as needed to monitor caloric intake, estimate needs, and make recommendations for changes to the tube feeding as needed. Furthermore, Resident #22 was dependent for tube feeding and water flushes and to reference the physician orders for current feeding orders.Review of Resident #22's physician orders revealed orders written on 12/16/25 for the resident to receive nothing by mouth (NPO), to receive Jevity 1.5 at 45 milliliters (ml) per hour with a water flush of 130 ml every four hours, check feeding tube placement every shift, and to check for tube feed residuals each shift. On 12/19/25 an order was written to clear the feeding pump and document intake of the amount of Jevity 1.5 daily on the night shift. The tube feed order for Jevity 1.5 was changed on 01/27/26 to 50 ml per hour from 9:00 A.M. until 7:00 A.M. Review of Resident #22's Medication and Treatment Administration Record (MAR/TAR) for December 2025 revealed no tube feeding was documented as being administered on 12/19/25 and 12/20/25. Further review of the MAR/TAR revealed an intake of 2723 ml of tube feeding was documented as being administered on 12/27/25. Review of the MAR/TAR for January 2026 revealed no tube feeding was documented as being administered on 01/06/26, 01/07/26, 01/20/26, and 01/31/26. Tube feed residuals were not completed on 01/05/26 and 01/24/26 for the evening shift, or on 01/19/26 and 01/31/26 for the day shift. Feeding tube placement was not checked on 01/01/26 and 01/24/26 on the evening shift and 01/19/26 and 01/31/26 on the day shift. Tube feed residuals were not completed on the day shift on 01/19/26 and 01/31/26 and on the evening shift on 01/05/26 and 01/24/26. Further review of the MAR/TAR revealed the amount of tube feeding documented as administered on 01/08/26, 01/09/26 and 01/23/26 was zero with a range of between 858 ml to 3626 ml of tube feeding being administered on the other days. Review of the MAR/TAR for February 2026 revealed no tube feeding was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented as being administered on 02/01/26, 02/05/26, 02/06/26, 02/10/26, 02/11/26, 02/15/26, 02/18/26 and 02/19/26 as ordered and a range of between 30 ml to 2420 ml of tube feed being administered on the other days of the month. Feeding tube placement was not checked on 02/06/26 and 02/19/26 on the night shift. Tube feed residuals were not completed on 02/06/26 for the night shift. Interview on 05/27/26 at 1:10 P.M. with the Registered Nurse Director of Nursing (RN DON) #84 verified for the months of December 2025 and January and February 2026 there were multiple dates where no documentation was recorded regarding the amount of tube feeding that was administered to Resident #22, where feeding tube placement was not verified, and tube feeding residuals were not checked. Furthermore, RN DON #84 verified on multiple dates in December, January, and February, the facility documented Resident #22 was administered a volume of tube feeding that was not consistent with the physician order.Review of the facility policy titled Enteral Nutrition, revised January 2014 revealed adequate nutritional support through enteral feeding will be provided to residents as ordered.This deficiency represents non-compliance investigated under Complaint Number 2789196.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on the review of the staffing schedules, review of the timecard reports, and staff interview, the facility failed to ensure a Registered Nurse (RN) was designated as the Director of Nursing (DON) on a full-time basis and further failed to ensure an RN was working in the facility at least eight consecutive hours per day, seven days a week. This had the potential to affect all residents. The facility census was 21.Findings include:Review of the facility staff schedules and the staff timecards for the week of 05/03/26 through 05/09/26 revealed a Registered Nurse (RN) did not work on 05/07/26 and 05/08/26. Further review revealed a Director of Nursing (DON) was not present in the facility on 05/05/26 through 05/09/26.Interview on 05/26/26 at 11:41 A.M. with Licensed Practical Nurse (LPN) #55 revealed the facility did not currently have a DON. LPN #55 stated RN, DON #82 came every Wednesday to serve as both the DON, and a RN and DON #84 came two days a week to serve as the DON for the facility. LPN #55 was unable to recall any other persons serving as DON in the facility since RN, DON #85 quit.Interview on 05/26/26 at 11:59 A.M. with RN #79 revealed RN, DON #84 was the current DON. RN #79 stated she was unaware of how often RN, DON #84 was in the facility and stated LPN #55 would know as she was in the facility more often than her.Interview on 05/27/26 at 8:00 A.M. with RN, DON #84 revealed she is the Regional Nurse and does not punch a clock and did not have any documentation to support that she had worked in the facility since the previous Director of Nursing left on 04/29/26. Interview on 05/27/26 at 10:31 A.M. with RN, DON #82 revealed she worked in the facility twice on 05/13/26 and 05/20/26 and did not work in the facility at all from 05/03/26 to 05/09/26.Interview on 05/27/26 at 10:34 A.M. with RN, DON #83 revealed the only date she worked in the facility was 05/04/26 and did not work 05/05/26 through 05/09/26.Interview on 05/27/26 at 10:58 A.M. with the Director of Operations (DOO) #86 verified RN, DON #83 was only in the facility on 05/04/26. DOO #86 stated that RN, DON #82 was serving as the DON however RN, DON #82 was only in the building the last two Wednesdays, 05/13/26 and 05/20/26. DOO #86 verified there was no DON coverage in the facility for 05/05/26 through 05/09/26. Furthermore, DOO #86 verified there was no RN in the facility on 05/07/26 and 05/08/26 as required.Upon request of a policy regarding full time DON coverage and RN hours in the facility, RN, DON #84 verified the facility did not have a policy as they follow the regulation.This deficiency represents non-compliance investigated under Master Complaint Number 2989641 and Complaint Number 2805820.