STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366003	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Care Center of Franklin Furnace	4734 Gallia Pike Franklin Furnace, OH 45629

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews and facility policy review, the facility failed to ensure residents were permitted to be served or consume tubular meats (various encased meats that are shaped into a tubular form) whole. This affected one resident (#13) of two residents reviewed for choices. The facility census was 24. Findings Include:Review of the medical record for Resident #13 revealed an initial admission date of 09/23/24 with a readmission date of 02/24/26. Diagnoses included cirrhosis of the liver, hypomagnesemia, pruritus, cyst of pancreas, ventral hernia, COPD, respiratory failure, esophageal varices, ESBL resistance, dysphagia, major depressive disorder, hypothyroidism, rheumatoid arthritis with rheumatoid factor, neuropathy, morbid obesity, heart failure and hepatic encephalopathy. Review of the care plan dated 10/01/24 revealed the resident was at risk for nutrition/hydration problems related to obesity status, diuretic medication use, poor dental status, inadequate intakes at times, cirrhosis of liver, hypomagnesemia, cyst of pancreas, obesity, heart failure, hypertension, hepatic encephalopathy and resident desires to loose weight. Interventions include allow the resident to make choices/preferences of food as able and observe resident for coughing, choking, chewing problems, pocketing food, drooling and/or holding food in mouth and provide diet as ordered. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident required supervision or touch assistance with eating. The resident received a therapeutic diet and had no swallowing issues. Review of the resident's monthly physician orders for April 2026 identified orders dated for No added salt, regular texture, regular consistency. On 04/27/26 at 1:40 P.M., an interview with Resident #13 revealed she was not allowed to have hot dogs unless they were cut up. She said they chop them up and put them in a bun to eat due to another resident choking in a facility up north and now they were punished for it. On 04/29/26 at 12:12 P.M., an interview with Dietary Manager (DM) #139 revealed a resident choked in a facility up north and now the company banned them from serving any meat that are tubular, like hot dogs, sausage links and smoke sausage. Dietary Manager (DM) #139 revealed the facility is now permitted to serve hot dogs however they must be cut up. [NAME] #126 revealed the hot dogs are cut in quarter pieces. On 04/29/26 at 2:17 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) verified the facility does not serve tubular meats and hot dogs must be cut up. Review of the facility policy titled, Resident Rights, last revised 12/16 revealed employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to self-determination and exercise his or her rights as a resident of the facility. Review of the facility policy titled, Safe Preparation and Serving of Tubular Meats, undated revealed the facility will ensure that tubular meats (hot dogs, sausages, kielbasa) are prepared and served in a manner that minimizes choking risk and promotes resident safety. The facility defined tubular meats as cylindrical shaped processed meats that pose a high choking risk due to their size, shape and texture, especially for individuals with dysphagia or impaired chewing/swallowing ability. Residents will be assessed for swallowing ability and dietary needs by Speech Therapy and/or nursing as indicated. Diet orders must be followed as prescribed.

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** Based on observation, medical record review, interview and facility policy review, the facility failed to ensure resident representatives were notified of changes in condition. This affected one resident (#25) of 15 sampled residents. The facility census was 24. Findings Include:Review of the medical record for Resident #25 revealed an admission date of 06/07/23. Diagnoses included hypertension, hyperlipidemia, anxiety disorder, history of MRSA, legal blindness, adult failure to thrive, chronic conjunctivitis, osteoarthritis, congestive heart failure, Vitamin D deficiency, adjustment disorder with depressed mood, major depressive disorder, dysphagia, age related nuclear cataract and diabetes mellitus. Review of the care plan dated 06/20/23 revealed the resident was at risk for skin breakdown related to decreased mobility, diabetes mellitus, incontinence, picking at her skin intermittent, moisture associated skin damage (MASD) and has current treatment for MASD with treatment in place. Interventions included administer medication as ordered, refuses treatment at times, encourage resident to comply and explain risks and benefits, apply lotion to day skin as needed, apply treatment as ordered, assist resident to the bathroom as needed, provide, provide peri care after each incontinence episode, apply barrier cream after incontinence care, pressure redistribution mattress to bed, and wheelchair cushion as ordered. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was at risk for skin breakdown and had no skin issues. Review of the initial weekly non-pressure skin gird dated 03/15/26 revealed the resident was found to have shearing to her left buttock measuring 0.5 cm by 0.5 cm. The assessment had no description of the wound, however, did document the wound was blanchable. Review of the medical record revealed no documented evidence the resident's representative was notified of the skin impairment, MASD. Review of the weekly non-pressure skin grid revealed the skin tear to the resident's face measured 2.0 cm by 1.0 cm. The resident was observed picking her face causing the skin tear. Review of the medical record revealed no documented evidence the resident's representative was notified of the new skin impairment. On 04/29/26 1:55 P.M., an interview with the Director of Nursing (DON) verified the facility had no documented evidence the resident's representative was notified of the new skin impairments. Review of the facility policy titled, Change In Condition and Physician Notification Policy, last revised in 09/19 revealed the facility was to promptly identify, respond to and report changes in condition in resident condition to the resident's physician, Nurse Practitioner (NP), Physician Assistant (PA), resident and/or representative. The nurse will document timely regarding the change in resident's condition, interventions and notifications.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and facility policy review, the facility failed to ensure comprehensive wound assessments were conducted and failed to monitor burns for worsening skin impairment and signs/symptoms of infection. The facility also failed to ensure physician orders were implemented as ordered. This affected two residents (#25 and #26) of three residents reviewed for wounds and one resident (#27) of five residents reviewed for unecessary medications. The facility census was 24. Findings Include:1. Review of the medical record for Resident #25 revealed an admission date of 06/07/23. Diagnoses included hypertension, hyperlipidemia, anxiety disorder, legal blindness, adult failure to thrive, chronic conjunctivitis, osteoarthritis, congestive heart failure, Vitamin D deficiency, adjustment disorder with depressed mood, major depressive disorder, dysphagia, age related nuclear cataract and diabetes mellitus. Review of the care plan dated 06/20/23 revealed the resident was at risk for skin breakdown related to decreased mobility, diabetes mellitus, incontinence, picking at her skin intermittent, moisture associated skin damage (MASD) and has current treatment for MASD with treatment in place. Interventions included administer medication as ordered, refuses treatment at times, encourage resident to comply and explain risks and benefits, apply lotion to day skin as needed, apply treatment as ordered, assist resident to the bathroom as needed, provide, provide peri care after each incontinence episode, apply barrier cream after incontinence care, pressure redistribution mattress to bed, and wheelchair cushion as ordered. Review of the initial weekly non-pressure skin gird dated 03/15/26 revealed the resident was found to have shearing to her left buttock measuring 0.5 cm by 0.5 cm. The assessment had no description of the wound, exposed tissue type or exudate. The facility implemented the treatment to cleanse the wound, apply triad past and leave open to air. Review of the weekly non-pressure skin grid dated 03/22/26 revealed the shearing wound measured 0.4 cm by 0.4 cm. The assessment had no description of the wound, exposed tissue type or exudate. The facility determined the wound had improved. Review of the resident's monthly physician orders for April 2026 identified orders dated 03/25/26 apply triad paste to left buttocks daily and as needed for wound care and 04/23/26 for monitor scab under left eye until resolved. Review of the weekly non-pressure skin grid dated 03/30/26 revealed the shearing wound measured 0.2 cm by 0.2 cm. The assessment had no description of the wound, exposed tissue type or exudate. The facility determined the wound had improved. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident required substantial/maximal assistance with toileting and dependent on staff for bed mobility and transfer. The resident was always incontinent of both bowel and bladder. The assessment indicated the resident was at risk for skin breakdown and had no skin issues. Review of the weekly non-pressure skin grid dated 04/06/26 revealed the shearing wound measured 0.2 cm by 0.2 cm. The assessment had no description of the wound, exposed tissue type or exudate. The facility determined the wound was unchanged. Review of the weekly non-pressure skin grid dated 04/13/26 revealed the shearing wound measured 0.2 cm by 0.2 cm. The assessment had no description of the wound, exposed tissue type or exudate. The facility determined the wound was unchanged. Review of the weekly non-pressure skin grid dated 04/20/26 revealed the shearing wound measured 0.2 cm by 0.2 cm. The assessment had no description of the wound, exposed tissue type or exudate. The facility determined the wound was unchanged. Review of the Wound Nurse Practitioner (WNP) progress note dated 04/29/26 revealed the WNP was completing the initial evaluation of the wound to the left buttocks. The WNP classified the wound as moisture associated skin damage (MASD) measuring diffuse (when the boundary between the wound and surrounding healthy tissue is not sharp or clearly demarcated. The wound tissue gradually merges with adjacent skin making it difficult to determine exactly where the wound begins and ends.) by diffuse by 0.1 centimeters (cm). The wound was described as 100 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	percent pink tissue. The WNP implemented the treatment to cleanse the wound with wound cleanser, apply triad paste and leave open to air daily and as needed. On 04/29/26 at 1:55 P.M., an interview with the Director of Nursing (DON) verified the wound assessments lacked a description of the wound, exposed tissue type or exudate. 2. Review of the medical record for Resident #26 revealed an initial admission date 12/11/25 with a readmission date of 04/20/26. Diagnoses included chronic gout, dysphagia, diabetes mellitus, atrial fibrillation, hyperlipidemia, chronic kidney disease, gastro-esophageal reflux disease, hypertension, anxiety disorder, depression, congestive heart failure, otitis media, chronic obstructive pulmonary disease and acute respiratory failure with hypercapnia. Review of the care plan dated 04/09/26 revealed the resident was receiving wound management related to left thigh blister. Interventions included complete treatment as ordered, keep area clean and dry, monitor for signs/symptoms of infection, obtain measurements weekly and as resident will allow, supplements as ordered and will follow with Wound Nurse Practitioner (WNP). Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The resident required supervision or touching assistance with eating. The assessment indicated the resident was at risk for skin breakdown, however had no skin issues. Review of the progress note dated 04/05/26 at 2:19 revealed the resident had spilled ramen noodles on her left leg while sitting in her recliner attempting to eat. The left leg was assessed and found to be pink with no blistering. The nurse applied a cool rag, and the resident stated it helped and she was feeling better. Review of the state tested nursing assistant (STNA) shower assessment sheet dated 04/05/26, authored by the Director of Nursing (DON) revealed the resident had a pink/reddened area to the left thigh measuring 2.0 centimeters (cm) by 2.0 cm. Review of the medical record revealed no monitoring of the burn for worsening skin impairment, pain or signs/symptoms of infection until 04/07/26 when the resident was found to have a blister to her left thigh. Review of the progress note dated 04/07/26 revealed a blister to the left thigh from the incident occurring on 04/05/26. The resident reported discomfort to thigh. The WNP was made aware and a new order for Silvadene cream every shift was obtained. Review of the resident's discontinued physician orders identified an order dated 04/07/26 to monitor left leg for signs and symptoms of infection until resolved, Review of the weekly non-pressure skin grid dated 04/08/26 revealed the burn to the left upper thigh measured 8.9 centimeters (cm) by 3.4 cm and was a fluid filled blister. The assessment contained no description of the blister or surrounding tissue. Review of the initial evaluation WNP progress note dated 04/15/26 revealed the resident was being seen for a burn to the left thigh. The second degree burn to the left anterior mid-thigh measured 1.0 cm by 1.0 cm by 0.2 cm and described as 100% pink tissue and a reddened peri-wound with a scant amount of serous drainage. The WNP also documented the wound was epithelializing with visible cell migration. The WNP gave the order to cleanse with wound cleanser, apply triad past and cover with bordered gauze dressing daily and as needed. The facility was also to monitor for signs/symptoms of infection. Review of the resident's readmission nursing observation dated 04/20/26 revealed the resident was readmitted to the facility with a burn to her left thigh measuring 1.0 cm by 1.0 cm. Further review of the assessment revealed no description of the burn's appearance and surrounding tissue. Review of the wound NP progress note dated 04/22/26 revealed the second degree burn to the left anterior mid-thigh measured 1.0 cm by 1.0 cm by 0.2 cm with 100% pink tissue. The wound had a scant amount of serous exudate, and the peri-wound was reddened. The facility determined the wound was unchanged. The treatment of triad paste and leave open to air daily and as needed was continued. Review of the resident's monthly physician orders for April 2026 revealed no current physician orders for a treatment and monitoring of the second degree burn to the left anterior mid-thigh. On 04/29/26 at 2:53 P.M., an interview with Director of Nursing (DON) verified the ongoing monitoring of the burn should have occurred, had no current treatment in place and monitoring for signs/symptoms of infection as ordered by the WNP. On 04/30/26 at 9:42 A.M., observation of the burn to Resident #26' left mid-thigh with Licensed Practical Nurse (LPN) #121 revealed the wound had light pink-whitish pealing skin with a brownish scabbed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area approximately 0.2 cm around to the inner mid-thigh and the outer left mid-thigh had an open wound was approximately the size of a fifty cent piece that was light pink-red in color with a moderate amount of brownish drainage. Review of the facility policy titled, Wound Management Program, undated revealed wound assessment protocol consisted of wound type and location, stage, size, drainage, wound bed, surrounding skin condition and pain level. Document at least weekly and with any notable change, wound measurements, staging, dressing changes, resident response and pain level, interventions in care plan and resident/family education. 3. Review of the medical record for Resident #27 revealed an initial admission date of 04/29/29 with the latest readmission date of 01/28/23. Diagnoses included nicotine dependence, atrial fibrillation, diabetes mellitus, anxiety disorder, seasonal allergic rhinitis, insomnia, gastro-esophageal reflux disease, chronic pulmonary embolism, peripheral vascular disease, dysphagia, hypertensive retinopathy, chronic obstructive pulmonary disease, congestive heart failure, hypertension, major depressive disorder, hyperlipidemia, anemia, sleep anemia, diabetic neuropathy and restless leg syndrome. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the Vitamin D level results dated 03/19/26 revealed a level of 27 nanograms/milliliter (ng/ml) (normal 30-100 ng/ml). The physician typed the order Vitamin D3 5000 units by mouth daily on the lab result.Review of the medical record revealed the physician order for Vitamin D3 5000 units by mouth daily was not implemented.On 04/29/26 at 1:56 P.M., an interview with the Director of Nursing (DON) verified the physician's order for order Vitamin D3 5000 units by mouth daily was not implemented as ordered.Review of the facility policy titled, Physician Orders Policy and Procedure, dated 06/09/22 revealed the physician may send a signed and dated fax medical order.