STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366171	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cridersville Healthcare Center	603 East Main Street Cridersville, OH 45806

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 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** 34745 Based on review of medical records, resident and staff interview, and policy review, the facility failed to ensure the physician was notified when residents were not using non-invasive ventilators (NIVs) as ordered and notify the physician of abnormal vital signs. This affected three (#20, #25, and #30) of three residents reviewed who used NIVs in a facility census of 30. Findings included: 1. Review of the medical record for Resident #30 revealed admitted [DATE]. Diagnoses included bipolar disorder, respiratory failure, chronic obstructive pulmonary disease (COPD), and dependence on respirator. The resident was discharged on [DATE] to the hospital. Review of the Minimum Data Set (MDS) assessment from March 2024 revealed the resident was assessed with modified independence with decision making and required the use of supplemental oxygen and the need for NIV with no documentation of refusals during the assessment time frame. Review of Resident #30's care plan for potential for alteration in respiratory function related to COPD, pneumonia, and sleep apnea 01/07/22, reviewed on 04/20/24, revealed interventions which included to administer medications as ordered, administer supplemental oxygen and may use a portable oxygen tank, notify the physician of changes in respiratory status, and observe for signs or symptoms of dyspnea (shortness in breath). Review of Resident #30's physician orders revealed an order dated 04/01/24 that Resident #30 may use a portable oxygen concentrator with activity at two (2) liters via nasal cannula to maintain saturation greater than 90 percent (%) every shift related to COPD. Resident #30 also had an order dated 04/26/24 nursing to notify the physician if the resident's systolic blood pressure was less than 100 millimeters of mercury (mmHg) or greater than 175 mmHg, the diastolic blood pressure was less than 60 mmHg or greater than 100 mmHg, and heart rare was less than 50 beats per minute every day shift related to hypertension and every night shift for NIV with use complete nightly. The order contained specific settings for the NIV for nighttime use and as needed for naps and could be titrated for the resident's comfort every night. If abnormalities are noted, staff are to notify the physician and document notifications and abnormalities. (continued on next page)

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
	366171	A. Building B. Wing	06/13/2024

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30's vital signs record between 05/19/24 and 06/02/24 revealed the resident's oxygen saturation rates were obtained as ordered and were within normal limits except on 06/02/24 at 2:42 P.M. which revealed an 80% oxygen saturation rate with no further documentation of oxygen saturation rates obtained on 06/02/24. It was also noted Resident #30's oxygen saturation rates obtained on 05/20/24, 05/29/24, and 05/30/24 were the only entries that indicated Resident #30 utilized the NIV at night as ordered. Review of Resident #30's nursing progress notes from 05/17/24 to 06/02/24 revealed multiple entries related to the resident not using her NIV as ordered and the nurses provided education to Resident #30. There was no documentation in the progress notes of the physician or nurse practitioner being notified of Resident #30 not wearing the NIV. Further review of the progress notes revealed on 05/17/24 Resident #30 was educated by a previous director of nursing that serious bodily injury, including death, was possible if poisonous gases reached a level in the resident's body at night if she did not wear her oxygen as ordered. There was no documentation in the progress notes of the physician being notified on 06/02/24 of the resident's oxygen saturation being 80%. Review of a nurse practitioner progress note dated 05/23/24 revealed Resident #30 was non-compliant with wearing oxygen, following a fluid restriction, and wearing compression stockings. The nurse practitioner documented the resident was compliant with wearing NIV at bedtime due to resident's chronic respiratory condition to reduce risk if resident developing significant adverse medical complications and frequent hospitalization s. Interview on 06/06/24 at 10:11 A.M. with Medical Director (MD) #800 revealed he was not notified of Resident #30's low oxygen level on 06/02/24. MD #800 stated he did not receive any notifications about the resident until after she left the facility via emergency medical service (EMS). MD #800 stated he was not specifically notified of Resident #30's refusals to wear her NIV, but verified he knew the resident was non-compliant with her supplemental oxygen at times. Interview on 06/06/24 at 11:44 A.M. with Licensed Practical Nurse (LPN) #222 revealed she worked on 06/02/24 from 2:00 P.M. to 10:00 P.M. LPN #222 stated on 06/02/24 she found Resident #30 without her supplemental oxygen on and stated she put the oxygen back on the resident. LPN #222 stated Resident #30's oxygen saturation rate at that time was 80%, and verified she did not recheck the resident's oxygen levels after that or notify the physician. LPN #222 stated he just figured the resident's oxygen saturation rate would go up since she put the supplemental oxygen back on the resident. 2. Review of the medical record for Resident #20 revealed an admitted [DATE] with a most recent readmitted [DATE]. Diagnoses included acute respiratory failure, with hypoxia, dependence on respirator, COPD, and obstructive sleep disorder. Review of the most recent MDS assessment revealed Resident #20 was assessed with intact cognition, received oxygen therapy, and used a non-invasive mechanical ventilator. Review of Resident #20's current plan of care related to poor oxygen absorption revealed interventions which included monitoring and documenting changes in orientation, monitor for signs and symptoms of respiratory distress, and report to the doctor. (continued on next page)

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	366171	A. Building B. Wing	06/13/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's current physician's orders revealed the resident was ordered to offer an NIV for naps or rest periods every day and evening shift for acute respiratory failure with hypoxia. Any abnormalities with respiratory status were to be documented with notification to the physician nightly. Review of Resident #20's progress notes revealed on 05/21/24, 05/22/24, 05/25/24, 05/26/24, 05/30/24, 05/31/24, 06/03/24, and 06/04/24 the resident refused to wear the NIV at night time and was educated on benefits of wearing the device as ordered. Further review of the progress notes were absent for notification to the physician regarding refusals. 3. Review of the medical record for Resident #25 revealed an admitted [DATE]. Diagnoses included paraplegia, chronic respiratory failure, and dependence on a respirator. Review of an MDS assessment from March 2024 revealed Resident #25 had intact cognition, required oxygen therapy, and utilized NIV. Review of Resident #25's most recent plan of care related to poor oxygen absorption included interventions to monitor and document changes in orientation, monitor signs and symptoms of respiratory distress, and report to the doctor. Review of Resident #25's current physician orders revealed an order for a NIV every night related to dependence on respirator. If abnormalities are noted, staff are to notify the physician and document notifications and abnormalities. Interview on 06/04/24 at 4:30 P.M. with Resident #25 revealed she had an NIV for some time now, but did not like to use it. Resident #25 stated she recently had concerns with her respiratory status, so she tired to wear it more often, but was not wearing every night as ordered. Review of Resident #25's progress notes from 05/16/24 to 06/05/24 were absent for notifications to the physician regarding Resident #25 not using the NIV at night time. Interview on 06/05/24 at 2:30 P.M. with the assistant director of nursing (ADON)# 600 revealed residents (#20, # 25, #30) here who are to wear the NIV at night are not compliant with using it, we educate the residents on the importance of wearing the device. She had not made notification to the doctor regarding non-compliance of NIV. Interview on 06/06/24 at 10:11 A.M. with Medical Director revealed he was not notified of the low blood pressure or low oxygen level. He did not receive any notifications about the resident until after the squad had left with the resident. He stated he would have probably had them observe her. He was not specifically notified of her refusals for NIV but he knew she was non-compliant with her 02 at times. He also informed me she passed away in the morning of 06/05/24. Interview on 06/05/24 at 2:00 P.M. with Assistant Director of Nursing (ADON) #500 revealed the residents who are supposed to wear their NIV at night are not compliant with using them. ADON #500 stated the facility staff educated the residents on the importance of using the devices but verified she had not notified the physician of the residents' non-compliance with the NIV. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/10/24 at 2:05 P. M. with Interim Director of Nursing (IDON) #600 verified Resident #20, Resident #25, and Resident #30 were not complaint with wearing their NIV and their was no documentation to the physician regarding their refusals. IDON #600 stated the documentation in the nurse practitioner's progress note regarding Resident #30's compliance with her NIV verified the nurse practitioner was not notified of the resident's non-compliance because Resident #30 was not compliant. Review of the facility policy titled, Change in Condition or Status, revealed the facility shall notify the resident, his or her attending physician, and representatives of changes in the residents medical or mental status. The nurse will notify the resident's attending physician or physician on call when there has been a significant change with specific instructions to notify the physician of changes in the resident's condition or vital signs being outside the recommended parameters.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 34745 Based on review of a closed medical record, review of hospital documentation, review of an emergency medical services (EMS) run detail report, review of a facsimile (fax) document, staff interviews, and review of facility policy, the facility failed to ensure a resident (#30) was provided appropriate and timely treatment, care, and services when the resident was assessed with changes in condition. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, negative health outcomes, and/or death when Resident #30 was ordered supplemental oxygen and a non-invasive ventilator (NIV) for use to aid the resident's respiratory status. Resident #30 was noted to refuse the NIV without notification to the physician and subsequently was assessed with low blood pressure and a low oxygen saturation rate on [DATE] which were not timely or appropriately reassessed, reported to the physician, or rechecked prior to providing medications to the resident. The lack of timely and appropriate care, services, and notification to the physician contributed to Resident #30's untimely death when she was found in her room with blue lips, removing her shirt and supplemental oxygen, was unable to answer questions, and her eyes were rolled in the back of her head. Resident #30 became unresponsive and absent of vital signs and was sent to the hospital where the resident was placed on a ventilator in the intensive care unit (ICU) and subsequently died . This affected one (#30) of three residents reviewed for appropriate care and services. The facility census was 30. On [DATE] at 3:19 P.M., the facility Administrator and Interim Director of Nursing (IDON) #600 were notified Immediate Jeopardy began on [DATE] at 6:42 A.M. when staff failed to provide Resident #30 with appropriate and timely treatment, care, and services after being assessed with a change in condition. Resident #30 was assessed as hypotensive (low blood pressure) on [DATE] at 6:42 A.M. and had low oxygen saturation levels at 2:42 P.M. with no recheck of the resident's blood pressure, no follow up assessments completed, no notification to the physician regarding the low oxygen saturation levels was made, and no recheck of the oxygen saturation level or respiratory assessment was completed. Resident #30 was then given antianxiety and narcotic pain medications at 4:15 P.M. and subsequently was found in her room with blue lips, removing her shirt and supplemental oxygen, was unable to answer questions, and her eyes were rolled in the back of her head. Resident #30 became unresponsive and absent of vital signs which required the facility staff to initiate cardiopulmonary resuscitation (CPR). Resident #30 was sent to the hospital via EMS where the resident was placed on a ventilator in the ICU and subsequently died on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 4:00 P.M., an interdisciplinary team (IDT) Quality Assessment and Assurance (QAA) meeting was held to discuss and develop a plan with Medical Director #800. The plan was reviewed through discussion with the Administrator, Regional Director of Operations (RDO) #700, IDON #600, and the [NAME] President Director of Clinical Services (VPDCS) #707. On [DATE] at 4:00 P.M., MD #800 was notified of the Immediate Jeopardy and review of the facility change in condition policy and plan for corrective action was reviewed with no changes made. On [DATE] at 4:00 P.M., the change in condition policy was reviewed by the Administrator and IDON #600 with no changes made. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:00 P.M., IDON #600 and Assistant Director of Nursing (ADON) #500 provided education to all Licensed Practical Nurses (LPNs) and Registered Nurses (RNs), including managers, on the facility change in condition policy and staff response to a change in condition. All nurses were educated by 9:50 P. M. with a plan for no nurses on leave and no agency nurses would be able to work without receiving the education. On [DATE] at 4:30 P.M., all resident medical records were reviewed by IDON #600 and ADON #500 to review vital signs, oxygen saturation, and the resident's physical condition. The focus of the medical review reviews was to determine if the resident was within their normal baseline and if not, notification to the physician would be made. On [DATE] at 7:00 P.M., all resident medical records were reviewed by IDON #600 and ADON #500 to review for change in condition. All identified changes in resident condition were notified to the physician. On [DATE], an audit tool was implemented to monitor resident charts relating to any change in condition, adverse effects, and specifically, assessments for changes in condition as it related to change in condition notification. IDON #600 and/or ADON #500 will review documentation of at least 20 percent (%) of the total resident census utilizing the audit tool to ensure notification of change was made and proper care and services were implemented. The audits will continue daily for two weeks, then three times a week for the third week, and then twice a week for the fourth week to ensure compliance. The audit tools will be presented in weekly QAA committee meetings for four weeks to determine the need to continue the plan, make any changes to the plan, or stop the audits if compliance has been achieved. On [DATE], two (#20 and #25) additional resident medical records were reviewed for appropriate care and services with a change in condition with no concerns identified. On [DATE], between 9:00 A.M. and 4:00 P.M., LPN #203, LPN #206, ADON #500, and IDON #600, verified they were educated on the facility's polices related to treatment of a change in condition, physician notification of a change in condition, and to document all assessments, including follow up assessments, of all abnormal vital signs. All staff members interviewed were knowledgeable about the education content and felt confident the information could be applied during their work tasks. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included bipolar disorder, respiratory failure, chronic obstructive pulmonary disease (COPD), diabetes mellitus, fatigue, chronic pain syndrome, dependence on respirator, cocaine abuse, schizoaffective disorder, and non-compliance with medication regimen. The resident was discharged to the hospital on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #30 from [DATE] revealed the resident was assessed with modified independence in regard to decision-making. Resident #30 was assessed to utilize supplemental oxygen or NIV with no refusal of care assessed during the review period. Review of Resident #30's care plan for potential for alteration in respiratory function related to COPD, pneumonia, and sleep apnea, dated [DATE] and reviewed [DATE], revealed interventions which included to administer medications as ordered, administer supplemental oxygen and may use a portable oxygen tank, notify the physician of changes in respiratory status, and observe for signs or symptoms of dyspnea (shortness in breath). Review of Resident #30's care plan for chronic pain, dated [DATE] and reviewed [DATE], revealed interventions which included to administer analgesics per order, anticipate need for pain relief and respond immediately to complaints of pain, evaluate effectiveness of pain interventions, and identify and record side effects and impact on function. Review of the physician orders for Resident #30 revealed an order dated [DATE] for the narcotic pain medications Tramadol 50 milligrams (mg) to give two tablets by mouth four times a day and an ordered Percocet ,d+[DATE] mg to give one tablet by mouth four times a day for pain on [DATE]. Resident #30 was ordered the antianxiety medication Lorazepam one (1) mg to give one tablet by mouth once every 24 hours as needed on [DATE]. Resident #30 was ordered the blood pressure medication Metoprolol 50 mg to give one tablet by mouth daily with instructions to hold for systolic blood pressure less than 110 millimeters of mercury (mmHg) or heart rate less than 60 beats per minute on [DATE]. Resident #30 was ordered the antianxiety medication Clonazepam 1 mg by mouth three times daily. Resident #30 was ordered the combination drug for treatment of COPD Ipratropium 0.5 mg - albuterol three (3) mg (2.5 mg base) per milliliter (ml) to inhale 3 mls orally every four hours as needed for shortness of breath on [DATE]. Further review of Resident #30's physician orders revealed an order dated [DATE] that Resident #30 may use a portable oxygen concentrator with activity at two (2) liters via nasal cannula to maintain saturation greater than 90% every shift related to COPD. Resident #30 also had an order dated [DATE] for nursing to notify the physician if the resident's systolic blood pressure was less than 100 mmHg or greater than 175 mmHg, the diastolic blood pressure was less than 60 mmHg or greater than 100 mmHg, and heart rate was less than 50 beats per minute every day shift related to hypertension and every night shift for NIV with use completed nightly. The order contained specific settings for the NIV for nighttime use and as needed for naps and could be titrated for the resident's comfort every night. If abnormalities are noted, staff are to notify the physician and document notifications and abnormalities. Review of Resident #30's vital signs between [DATE] and [DATE] revealed the resident's vital signs were within normal limits except on [DATE] when the residents blood pressure was ,d+[DATE] mmHg. Review of the vital signs for Resident #30 revealed on [DATE] at 6:42 A.M. the resident had a blood pressure of , d+[DATE] mmHg with a heart rate of 55 beats per minute. Further review of Resident #30's vital signs revealed Resident #30 had no other documented blood pressure obtained on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of Resident #30's vital signs record between [DATE] and [DATE] revealed the resident's oxygen saturation rates were obtained as ordered and were within normal limits except on [DATE] at 2:42 P. M. which revealed an 80% oxygen saturation rate with no further documentation of oxygen saturation rates obtained on [DATE]. It was also noted Resident #30's oxygen saturation rates obtained on [DATE], [DATE], and [DATE] were the only entries that indicated Resident #30 utilized the NIV at night as ordered. Review of Resident #30's nursing progress notes from [DATE] to [DATE] revealed multiple entries related to the resident not using her NIV as ordered and the nurses provided education to Resident #30. There was no documentation in the progress notes of the physician or nurse practitioner being notified of Resident #30 not wearing the NIV. Further review of the progress notes revealed on [DATE], Resident #30 was educated by a previous director of nursing that serious bodily injury, including death, was possible if poisonous gases reached a level in the resident's body at night if she did not wear her oxygen as ordered. Review of a nurse practitioner progress note dated [DATE] revealed Resident #30 was non-compliant with wearing oxygen, following a fluid restriction, and wearing compression stockings. The nurse practitioner documented the resident was compliant with wearing NIV at bedtime due to resident's chronic respiratory condition to reduce risk if resident developing significant adverse medical complications and frequent hospitalization s. Review of nursing progress notes between [DATE] and [DATE] revealed no significant issues with Resident #30's blood pressure or oxygen saturation rates, and no identification of any changes in condition. Review of a fax document sent to Medical Director #800 on [DATE] at 6:47 A.M. revealed LPN #207 sent a notification that Resident #30 had a blood pressure of ,d+[DATE] mmHg and a heart rate of 55 beats per minute. LPN #207 documented Resident #30 had her blood pressure medication held. Further review of a return fax document from Medical Director #800 revealed no instructions to the nurse for continued assessment, treatment, or care of Resident #30 following the low blood pressure reading. The only documentation from Medical Director #800 on the returned fax document was an illegible mark on the bottom right corner of the document. Review of Resident #30's [DATE] medication administration record (MAR) revealed on [DATE] the resident received an as needed breathing treatment of Ipratropium albuterol solution 3 mls inhaled for shortness of breath at 1:06 P.M. at which time the resident's oxygen saturation rate was 97%. At 2:07 P.M., Resident #30 received as needed Lorazepam for anxiety. Further review of the [DATE] MAR revealed Resident #30 received scheduled Tramadol 50 mg and Clonazepam 1 mg by mouth both at 3:00 P.M. as ordered. Resident #30 was also administered both Percocet ,d+[DATE] mg and Clonazepam 1 mg at 4:15 P.M. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of nursing progress notes on [DATE] revealed a note entered at 1:06 P.M. which revealed Resident #30 received a breathing treatment due to the resident stating she could not breathe. Review of a progress note entered at 9:04 P.M. revealed Resident #30 was given Clonazepam 1 mg and Percocet ,d+[DATE] mg at 4:15 P.M. on [DATE]. State tested Nurse Aide (STNA) #124 entered the resident's room to answer the resident's call light. STNA#124 entered the room to find Resident #30 removing her shirt and oxygen tubing, and STNA #124 noticed Resident #30's lips were blue. STNA #124 asked Resident #30 what she needed but when the resident tried to respond, she was not able to talk and continued to remove her shirt and oxygen tubing. LPN #208 went to assess the situation and the nurse discovered Resident #30's eyes were rolled back in her head. Resident #30 was moved to the floor and staff began CPR. EMS were called while staff continued CPR until EMS arrival. Resident #30 was sent to a local hospital and at last report was on a ventilator and moved to the ICU. Further review of progress notes from [DATE] revealed no documented evidence of staff reassessing the resident's respiratory status, oxygen saturation levels, or notification to the physician regarding the resident's change in condition until Resident #30 left the facility via EMS. Review of an EMS run detail report dated [DATE] at 4:26 P.M. revealed dispatch was initiated for an unresponsive but breathing female (Resident #30). Upon response, dispatch was advised CPR was being initiated by nurses. EMS arrived on scene to find Resident #30 supine on the floor with CPR in progress. Resident #30 was unresponsive, apneic (not breathing), and had no pulse upon EMS arrival at the facility. Resident #30's skin was pale, dry, and cool to the touch. EMS continued CPR while the resident was transported to the hospital; however, the resident remained in asystole (no heart activity) throughout the transport. Resident #30's nurse advised that she came to check on the resident and noticed she was unresponsive and barely breathing. The nurse checked for a pulse, but no pulse was found. Review of hospital documentation revealed Resident #30 was examined on [DATE] with a chief complaint of pulseless electrical activity (PEA). Per the nursing facility, Resident #30 stated she was not feeling well, was given three different medications, then suddenly collapsed without a pulse. Resident #30 was transported to the hospital via EMS. A computed tomography scan of the resident's chest revealed there was not a pulmonary embolism but identified severe pneumonia bilaterally with infectious agents of extended-spectrum beta-lactamase (ESBL) and Methicillin-Resistant Staphylococcus Aureus (MRSA) which was highly suspicious for an aspiration event resulting in pneumonia, likely from the facility. Resident #30 was diagnosed were PEA, anoxic brain injury, sepsis with shock, acute chronic hypoxia hypercapnic respiratory failure with aspiration pneumonia, new onset of atrial flutter with rapid ventricular rate (RVR), acute kidney injury, renal failure, and subacute T6 mildly commuted fracture. Interview on [DATE] at 2:00 P.M. with ADON #500 revealed the residents, including Resident #30, who are supposed to wear their NIV at night are not compliant with using them. ADON #500 stated the facility staff educated the residents on the importance of using the devices but verified she had not notified the physician of the residents' non-compliance with the NIV. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 10:11 A.M. with Medical Director #800 revealed he was not notified of Resident #30's low blood pressure or low oxygen level on [DATE]. MD #800 stated he did not receive any notifications about the resident until after she left the facility via EMS. MD #800 stated, after reviewing the events of [DATE], he would have probably had the nursing staff observe Resident #30. MD #800 stated he was not specifically notified of Resident #30's refusals to wear her NIV, but verified he knew the resident was non-compliant with her supplemental oxygen at times. MD #800 notified the surveyor that Resident #30 died on the morning of [DATE]. Interview on [DATE] at 11:44 A.M. with LPN #222 revealed she worked on [DATE] from 2:00 P.M. to 10:00 P.M. LPN #222 verified she received shift report from the nurse working the previous shift but did not receive information that Resident #30 had a low blood pressure. LPN #222 stated she was the staff member who found Resident #30 without her supplemental oxygen on and stated she put the oxygen back on the resident. LPN #222 stated Resident #30's oxygen saturation rate at that time was 80%, and verified she did not recheck the resident's oxygen levels after that. LPN #222 stated she just figured the resident's oxygen saturation rate would go up since she put the supplemental oxygen back on the resident. LPN #222 verified she would not have administered Resident #30 her narcotic pain medications and antianxiety medications on her shift if she had known the resident's blood pressure was so low earlier in the morning. LPN #222 explained the medications she gave Resident #30 would suppress her respiratory system. LPN #222 confirmed she gave Resident #30 Clonazepam 1 mg and Percocet ,d+[DATE] one tablet by mouth at 4:15 P.M. on [DATE] and Resident #30 took them without any issues. LPN #222 stated around 4:20 P.M., STNA #124 told her she was needed in Resident #30's room as she was found unresponsive. LPN #222 stated she and STNA #124 moved Resident #30 to the floor and initiated CPR until EMS arrived at the facility. Interview on [DATE] at 4:40 P.M. with LPN #224 revealed she faxed the doctor about Resident #30's low blood pressure on [DATE]. LPN #224 stated she had Resident #30 elevate her feet and stated she rechecked the resident's blood pressure but could not remember what the blood pressure was or if she documented it. LPN #224 stated she informed the oncoming nurse about Resident #30's low blood pressure because the physician had not faxed back yet. LPN #224 verified she did not update the physician about Resident #30's ongoing low blood pressure. Review of the facility policy titled, Change in Residents Condition, dated ,d+[DATE], revealed the facility shall notify the resident, his or her representative of changes in the residents medical or mental condition. The nurse supervisor or charge nurse will notify the residents attending physician or on call physician when there has been a change in the resident's condition.