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	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cridersville Nursing and Rehab	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interview, and review of invoices and receipts, the facility failed to maintain a homelike environment for its residents. This affected four (#9, #16, #33, and #35) of 25 residents reviewed for physical environment. The census was 41. Findings include: 1. Record review for Resident #9 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, muscle weakness, and schizoaffective disorder.Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had impaired cognition and required assist from staff for bathing and daily hygiene needs.Review of Resident #9's care plans dated 08/19/25 revealed a focus for activity of daily living (ADLs) deficits. Interventions included staff to assist with all personal care.Observation on 09/23/25 at 10:00 A.M., during the initial tour, revealed Resident #9 was observed resting in her room. Resident #9 was unable to be interviewed due to her medical condition.2. Record review for Resident #16 revealed the resident was admitted to the facility on [DATE]. Diagnoses included encephalopathy, mood disorder, and chronic obstructive pulmonary disease.Review of the MDS comprehensive assessment dated [DATE] revealed Resident #16 had intact cognition and required only set-up assistance for daily hygiene. Observation on 09/23/25 at 10:00 A.M. revealed Resident #16 resided in the same room with Resident #9. Resident #16 was sitting on the side of her bed in the room. Interview on 09/23/25 at 10:02 A.M. with Resident #16 revealed since her admission to the facility in June 2025, the sink in her bathroom had been in disrepair. Resident #16 stated it disturbed her to have to walk to the other shower room down the hall in order to wash her face and brush her teeth. Resident #16 stated she was bothered by the fact she has to wait for all other residents, including the two (#12 and #30) residents residing in the room connected to the other shower room, to complete their care before her and her roommates could use the sink. Resident #16 stated she used the visitor bathrooms at times but those are also farther away from her room and during the evenings she would prefer to be able to use her own bathroom.3. Record review for Resident #35 revealed the resident was admitted to the facility on [DATE]. Diagnoses included acute kidney failure, diabetes type two, weakness, and malnutrition.Review of the MDS comprehensive assessment dated [DATE] revealed Resident #35 had intact cognition and required only set-up assistance for daily hygiene. Observation on 09/23/25 at 10:05 A.M. revealed Resident #35 was sitting on her bed in the same room as Resident #16 and Resident #9.Interview on 09/23/25 at 10:10 A.M. with Resident #35 revealed the resident stated the sink in her shared bathroom did not work properly when she admitted to the facility. Per Resident #35, the roommates and herself all reported the sink to the maintenance staff and were told the parts to fix the sink were being ordered. Resident #35 stated it was inconvenient to have to walk all the way down the hall to use some other resident's bathroom just to wash her hands. Resident #35 stated she reported her concerns with the bathroom issues to the staff with no resolution when she first admitted to the facility in July 2025. 4. Record review for Resident #33 revealed the resident was admitted to the facility on [DATE]. Diagnoses included hemiplegia, malnutrition, difficulty walking, and cerebral infarction. Review of the MDS comprehensive assessment dated [DATE] revealed Resident #33 had mildly impaired cognition and was a set-up only for daily hygiene. Interview on 09/23/25 at 10:15 A.M. with Resident #33 revealed she had fallen in the bathroom due to the sink being in disrepair in August 2025. Per Resident #33, the sink had been leaking in the past and was wobbly. Resident #33 stated she reported the sink to staff before in July 2025 and was told the sink was on back order and would be replaced but at the time of survey it still had not been fixed. Resident #33 stated it was inconvenient to walk all the way to the other shower room or visitor bathrooms to wash her hands or complete simple daily hygiene tasks. Observation on 09/23/25 at 10:40 A. M. of the shower room on the South unit revealed the room was accessible from the hallway and the room shared by Resident #9, Resident #16, Resident #33, and Resident #35. In the shower room there was a toilet and a shower with a shower curtain. Located next to the toilet there were water lines connected to a faucet and there was no porcelain basin connected to the wall. Interview on 09/23/25 at 1:35 P.M. with Certified Nurse Aide (CNA) #118 revealed the sink in the room shared by Resident #9, Resident #16, Resident #33, and Resident #35 on the South unit had been in disrepair for a long time. Per CNA #118 the staff and residents reported the need to repair the sink to the maintenance department and was told the sink was on a list of repairs and was ordered to be replaced. CNA #118 stated all personal care requiring a sink required the residents in the room to go to the other shared shower room or the visitor bathrooms. CNA #118

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and staff interview, the facility failed to initiate a care plan related to anticoagulation medication use. This affected one (#24) of three residents reviewed for care plans. The census was 41. Findings include: Review of medical record for Resident #24 revealed admission date of 06/24/25. The resident was admitted with diagnoses including end stage renal disease, diabetes mellitus, hyperkalemia, dependence on renal dialysis, heart failure, and intellectual disabilities. Review of Resident #24's physician orders dated 01/17/25 for revealed orders for the anticoagulant warfarin sodium Tablet eight (8) milligram (mg) and one (1) mg; to give 0.5 tablet of 1 mg with 8 mg to equal 8.5 mg by mouth one time a day for treating and preventing blood clots. Review of Resident #24's care plan dated 07/20/25 revealed the plan was absent for anticoagulants. Interview with the Director of Nursing (DON) on 09/24/25 at 2:34 P.M. verified Resident #24 did not have a plan of care for anticoagulant medication use. This deficiency represents an incidental finding discovered during the complaint investigation.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital documents, and resident and staff interview, the facility failed to prevent an avoidable fall. Actual harm occurred on 08/10/25 when Resident #33 was in the bathroom leaning on the sink. The sink broke loose from the wall, fell to the floor, and broke into pieces. Resident #33 subsequently fell on top of a sharp piece of the sink and sustained a five millimeter (mm) laceration which hemorrhaged blood and required hospitalization with sutures needed to close the wound. This affected one (Resident #33) of three residents reviewed for accidents. The census was 41. Findings include: Record review for Resident #33 revealed the resident was admitted to the facility on [DATE]. Diagnoses included hemiplegia, malnutrition, difficulty walking, and cerebral infarction. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #33 had mildly impaired cognition and required set-up only for daily hygiene. Review of Resident #33's care plans dated 06/10/25 revealed a focus for falls. Interventions include keeping the bedside table within reach, keeping the call light within reach, keeping the room free of clutter, and therapy as ordered. Review of Resident #33's weight records recorded on 08/02/25 revealed the resident weighed 115 pounds. Review of Resident #33's progress notes dated 08/10/25 at 7:30 P.M. revealed the nurse was alerted by staff and other residents that the resident had an unwitnessed fall. The nurse noted a trail of blood from the outer hallway to the bathroom and bedroom door. Resident #33 was found groaning in pain. There was a moderate amount of blood hemorrhaging from Resident #33's lower back side. The resident was assessed by the nurse, attempts to stop the bleeding were applied, and emergency medical services were contacted. The nurse documented Resident #33 said she was leaning against the sink momentarily to finish hygiene when the sink detached from the wall. She fell and the sink fell to the floor. Resident #33 said she landed on a sharp piece of the sink causing a laceration to the lower lumbar area. Resident #33 was transported to the hospital for evaluation and treatment, and the nurse contacted the maintenance director due to not being able to completely turn off the water flooding into the bathroom and hallway. Review of Resident #33's hospital documents, dated 08/10/25, revealed the resident was admitted to the hospital for treatment to a laceration obtained after a fall onto a sink at the nursing home. Resident #33 suffered a 5 mm laceration on her back and required six sutures for closure. The resident was treated for pain at the hospital and sent back to the facility on [DATE] with instructions on wound care. During an interview on 09/23/25 at 10:02 A.M., Resident #35 and Resident #16, both residents stated they did not see the actual fall Resident #33 sustained on 08/10/25 in the bathroom. Resident #35 and Resident #16 stated they heard Resident #33 fall and then cry out for help. Resident #16 stated she went to get staff help, and Resident #35 stated she activated her call light and went to see if she could help Resident #33. Both residents stated the staff responded quickly to help Resident #33 and emergency medical services took the resident quickly to the hospital. Resident #16 stated she and other residents reported their concerns with the broken sink to other staff including the maintenance department prior to 08/10/25. During an interview on 09/23/25 at 10:41 A.M., Corporate Maintenance Director (CMD) #1 verified the sink in the shower room was non-functional since 08/10/25 when the sink fell off the wall. During an interview on 09/23/25 at 1:12 P.M., Resident #33 stated the bathroom sink had been in disrepair since July 2025 but was totally broken after her fall in August 2025. Resident #33 did not provide any details regarding the fall at the time of the original interview but stated since the sink was still broken at the time of the survey and she was unable to do her daily hygiene regularly in her own bathroom. Resident #33 stated she was upset she had to walk down the hall to the other shower room on the other side of building in order to do simple tasks such as washing her face and brushing her teeth. During an interview on 09/23/25 at 5:00 P.M. Resident #33 stated she was showering and had her clothes on the sink. Resident #33 stated she was alone in the bathroom getting dressed after her shower when she felt she felt unstable. Resident #33 stated she leaned on the sink to steady herself and the sink then wobbled off the wall onto the ground causing her to fall on top of the sink and it cut her back. Resident #33 stated she was not using the water sink for hygiene at the time of the fall and stated the sink was wobbly prior to the day of her fall. Resident #33 stated she received sutures for the laceration and the staff acted quickly and got her to the hospital fast. Resident #33 stated she did have pain in her back from the laceration immediately after the fall; however, the resident stated she had no continued pain with the injury and the wound had since healed. During an interview on 09/23/25 at 4:22 P.M., Maintenance Director (MD) #116 stated on 08/10/25 the sink in the shared shower room adjacent to room