

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Cridersville Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and Guardian interviews, and policy review, the facility failed to ensure residents had access to their medications upon discharge. This affected one resident (#50) of two reviewed for discharge. The facility census was 50. Findings include: Findings include: Review of the medical record of Resident #50 revealed an admission date of 08/20/25. Diagnoses include anoxic brain injury, dementia, delusional disorder, and diabetes mellitus type II. Review of the discharge Minimum Data Set assessment dated [DATE] revealed Resident #50 was cognitively impaired. Review of the Discharge summary dated [DATE] revealed only the social service section had been completed. Resident #50, nor his guardian, had been instructed on medications, and/or treatments. Interview on 07/30/26 at 12:20 P.M. with the Administrator revealed the facility was unable to produce a completed discharge summary with instructions on medications and/or treatments for Resident #50. Interview on 7/30/26 at 12:50 P.M. with Resident #50's Guardian revealed she had been given instructions, but no medications had been sent home with Resident #50 and medications had been called into a pharmacy, however that pharmacy was in another city hours away. Review of the policy titled, Transfer and Discharge (including AMA), dated 1/23/25 revealed the transfer or discharge will be provided to the resident and resident's representative in a language and manner they can understand. The notice will include a recap of the residents' stay that includes diagnoses, course of treatment or therapy, and pertinent lab, radiology, and consultation results, along with a reconciliation of all pre and post medications. This deficiency represents non-compliance investigated under Complaint Number 3047386.		

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interviews, staff interviews, review of facility scheduled medication pass times, and policy review the facility failed to administer medications as ordered. This affected three (Residents #2, #7 and #30) out of six residents reviewed for medication. The facility census was 39. Findings include: 1. Record review for Resident #2 revealed the resident admitted to the facility on [DATE]. Diagnoses for Resident #2 include sepsis, chronic obstructive pulmonary disease, end stage renal dialysis with dependence on dialysis, and anxiety. Review of Resident #2's Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition, receiving dialysis, and was receiving anti-anxiety medications. Review of the care plans for Resident #2 revealed the care plans dated 7/6/25 revealed a focus for complications relating to dialysis treatments and a focus for anxiety relating to alterations in activities due to dialysis appointments. Intervention includes administering medications per physician order. Review of Resident #2's physician orders revealed on 11/18/25 the resident was ordered to receive Alprazolam 0.25 milligrams (mg) 1 tablet by mouth one time a day every Tuesday, Thursday, and Saturday prior to dialysis. Review of Resident #2's Medication Administration Records (MAR) dated 06/2026 and 07/2026 revealed the resident did not receive the Alprazolam medication on 06/29/26, 06/30/26, 07/02/26, 07/04/26, and 07/07/26. Per the MARs Resident #2 was not administered the ordered Alprazolam medication 9 times out of 24 scheduled times. Review of the progress notes for Resident #2 dated from 06/01/26 to 07/09/26 revealed on 06/29/26 and 06/30/26 the nurses documented the Alprazolam was 'unavailable need new script'. Per the note dated 07/02/26 at 5:20 A.M. the Alprazolam 0.25 mg tablet medication was unavailable, unable to pull, pharmacy needs new script. Per the note dated 07/02/26 at 1:15 P.M. the nurse noted a refill request for Alprazolam was faxed to the physician and the nurse was waiting a response. Per the note dated 07/04/26 at 5:21 A.M. the Alprazolam medication was unavailable, unable to pull, pharmacy needs new script. On 07/07/26 at 3:55 A.M. the nurse documented the Alprazolam 'new script'. No other nurses' notes were noted in the records. Interview on 07/28/26 at 3:45 P.M. with the Director of Nursing, (DON) verified the missing Alprazolam medications noted in Resident #2's MARs and progress notes. DON verified there were missing administrations of the medications due to the pharmacy not supplying the ordered medications in a timely manner. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #30 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #30 include alcoholic cirrhosis of the liver with ascites, bipolar disorder, depression, Wernicke's encephalopathy, and end stage renal disease. Further review of Resident #30's records revealed the resident was receiving hospice services. Review of Resident #30's MDS comprehensive assessment dated [DATE] revealed the resident had mildly impaired cognition and was receiving anti-anxiety medications. Review of Resident #30's care plans dated 09/16/25 revealed a focus for using anti-anxiety medications. Review of Resident #30's physician orders dated 12/13/25 revealed Resident #30 was ordered to receive Ativan 2 milligrams, (mg), two tablets for 4 mg dose six times a day for restlessness. Review of Resident #30's MARs dated 06/20/26 revealed on 06/15/26 there was two missed doses at 6:00 P.M. and 8:00 P.M. on 06/20/26 there were three missed doses at 6:00 A.M., 2:00 P.M., and 6:00 P.M. on 06/23/26 there were two missed doses at 2:00 A.M. and 6:00 A.M. on 06/24/26 there was two missed doses at 2:00 A.M. and 2:00 P.M. on 06/27/26 there was one missed dose at 6:00 P.M., and there were two missed doses at 2:00 A.M. and 6:00 A.M on 06/30/26. Review of Resident #30's progress notes dated 06/15/26 at 7:22 P.M. noted the Ativan 4 mg dose had been administered by previous nurse at 6pm too soon to give. No other documentation was noted for 06/15/26. Per the note dated 06/20/26 at 5:24 A.M. and 1:11 P.M. the nurse documented the Ativan medications was 'unavailable'. Per the note dated 06/20/26 at 5:01 P.M. the nurse documented the Ativan medication was 'on order'. Per the notes dated 06/23/26 the notes stated 'See nurse note' no corresponding note was in the medical records. Per the notes dated 06/24/26 at 2:02 A.M., and 1:26 P.M. the nurses documented, 'medication unavailable'. Per the note dated 06/27/26 at 7:08 P.M. the nurse documented the Ativan was 'day shift meds'. Per the notes dated 06/30/26 at 1:42 A.M. and 3:17 A.M. the notes stated 'See nurse note' no corresponding note was in the medical records. Interview on 07/28/26 at 3:45 P.M. with the DON while reviewing the MAR and the corresponding notations in the medical record revealed per the DON, the protocol for a medication being found unavailable at the time of administration was to contact pharmacy and/or contact physician for a new script. The DON verified there was no documentation stating the nurses had followed the protocols and ordered the Ativan medication for Resident #30 when the supply ran out. 3. Review of the medical record of Resident #7 revealed an admission date of 05/22/26. Diagnoses include systemic lupus erythematosus, neuropathy, pyogenic arthritis, hypertension, gastro-esophageal reflux disease, atherosclerotic heart disease, and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set assessment, dated 06/03/26, revealed Resident #7 was cognitively intact. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for Resident #7 for 07/26 revealed the following medications were scheduled to be administered at the A.M. hours: amlodipine 10 mg with parameters to hold if systolic blood pressure (SBP) was less than 90 milliliters of mercury (mm/hg), diastolic blood pressure (DBP) less than 60 mm/hg, or heart rate (HR) less than 60 beats per minute; aspirin 81 mg; clopidogrel 75 mg; doxycycline 25 mg/ml(milliliters) give 20 ml; lisinopril 2.5 mg; sertraline 25mg; tiotropium bromide-olodaterol inhalation 2 puffs; carvedilol 12.5 mg with parameters to hold if SBP less than 90, DBP less than 60, or HR less than 60; guaifenesin 600 mg; hydroxychloroquine 200mg; potassium chloride 40 milliequivalents/15 ml, give 10 ml; pregabalin 75 mg; topiramate 25 mg; and furosemide 40 mg. Interview on 07/27/26 at 11:00 A.M. with Resident #7 revealed he had not received any medications for the day. Review of the MAR for Resident #7 on 07/27/26 at 11:10 A.M. revealed no indication his morning medications had been administered at this time. Interview on 7/27/26 at 11:22 A.M. with Licensed Practical Nurse (LPN) #127 revealed she had not administered medications to Resident #7 as of this time because she was waiting to be able to administer his pain medication at the same time, which is available at 12:00 P.M. Review of the Medication Pass Times revealed morning med pass times were 7A-10A. Review of the policy titled, Medication Administration, dated 8/22/25 revealed the policy stated to administer within 60 minutes prior to or after scheduled time. This deficiency represents non-compliance investigated under Complaint Numbers 3072123 and 3064268.		