

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care of Coal Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 813 1/2 Marion Pike Coal Grove, OH 45638	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure comprehensive care plans to address Post Traumatic Stress Disorder (PTSD) and suicidal ideations were initiated. This affected two Residents (#3 and #4) of 18 resident care plans reviewed. The facility census was 53. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 02/11/25 and a readmission date of 07/25/25 with diagnoses including Post Traumatic Stress Disorder (PTSD), insomnia, anxiety, depression, diabetes mellitus type two and bilateral above the knee amputations. Review of the five day Medicare minimum data set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact with no behaviors. Resident #3 needed assistance from the staff to complete activities of daily living. Resident #3 had diagnoses of PTSD, anxiety and depression. Review of the plan of care for Resident #3 revealed no plan of care addressing the PTSD cause, resident triggers, resident reaction behaviors and staff interventions. Interview on 09/11/25 at 8:40 A.M. with the Administrator confirmed Resident #3 had diagnosis of PTSD and the care plan did not address the cause of the PTSD, the resident triggers, resident reaction behaviors and staff plan of action or interventions. 2. Review of the medical record for Resident #4 revealed an admission date of 01/03/23 and readmission date of 04/01/25 with diagnoses including senile degeneration of the brain, anxiety, suicidal ideations, seizure disorder, chronic kidney disease stage three, dementia and malignant neoplasm of overlapping sites of rectum, anus and anal canal. Review of the physician orders dated 09/25 revealed Resident #4 received Depakote sprinkles 125 milligrams (mg) by mouth two times daily for suicidal ideations and depression. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had severe cognitive impairment with inattention, disorganized thinking, hallucination, delusions, verbal behaviors towards others and rejection of care. Resident #4 was dependent on the staff to complete activities of daily living. Resident #4 had diagnoses including dementia, anxiety, depression and suicidal ideations. Resident #4 received antianxiety, antidepressant and anticonvulsant medications. Review of the care plan for Resident #4 revealed there was not a care plan addressing the resident's suicidal ideations. Interview on 09/10/25 at 2:47 P.M. with Certified Nursing Assistant (CNA) #470 stated there was nothing on Resident #4 point of care documentation about the resident having suicidal ideations. Interview on 09/11/25 at 8:40 A.M. with the Administrator confirmed Resident #4 had a diagnosis of suicidal ideations, received medication for suicidal ideations and did not have a plan of care addressing the suicidal ideations.		

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review and staff interview the facility failed to ensure there were parameters in place for administration of as needed pain medications and non-pharmacological interventions. This affected one resident (#5) of four residents reviewed for pain management. The facility census was 53. Findings include: Review of the medical record for Resident #5 revealed an admission date of 07/25/25 with diagnoses including chronic kidney disease stage three, unspecified psychosis, rheumatoid arthritis, diabetes mellitus and malignant nodule of the lung. Review of the Medication Administration Record (MAR) dated 08/25 and 09/25 revealed Resident #5 received Tylenol 650 milligrams (mg) by mouth every eight hours as needed for pain, Tramadol 50mg by mouth every six hours as needed for pain and no nonpharmacological interventions were ordered. Additionally, no pain level parameters noted of when to administer each medication. Review of the significant change in status Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was cognitively intact with verbal and physical behaviors towards others. Resident #5 was dependent on staff assistance for activities of daily living. Review of the plan of care initiated on 12/22/24 revealed Resident #5 would verbalize adequate relief of pain or the ability to cope with incompletely relieved pain. The goal stated Resident #5 would display a decrease in behaviors of irritability, agitation, restlessness, grimacing, hyperventilation, groaning and crying through the review date. The interventions included: administer medications as ordered, notify the physician as needed, nonpharmacological interventions, observe for side effects of pain medication, observe for signs and symptoms of nonverbal pain and provide therapy as needed. Interview on 09/10/25 at 9:10 A.M. with Resident #5 revealed no expressions or verbalization of pain. Interview on 09/10/25 at 2:55 P.M. with Licensed Practical Nurse (LPN) #200 confirmed Resident #5 did not have nonpharmacological interventions for pain. LPN #200 also stated if a resident had two as needed pain medications, she would administer one or the other based on the resident's pain level. Interview on 09/11/25 at 8:40 A.M. with the Administrator confirmed Resident #5 was ordered and received two different pain medications as needed without directions or parameters of what pain level to administer each one. Review of the Assessment, Intervention of as Needed Medication for Behavior and Pain Policy revised 09/2020 revealed the facility would evaluate and assess the resident's signs and symptoms, identify the specific area and type of pain, and attempt to use non-medication interventions to redirect, stop or reduce the identified pain such as one on one attention, redirection, repositioning and activities.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interviews, and review of facility policy, the facility failed to provide an adequate plan of care for post-traumatic stress disorder and ensure staff were knowledgeable in the plan of care. This affected one (Resident #20) of three residents reviewed for mood and behavior. The facility census was 53. Findings include: 1. Review of the medical record for Resident #20 revealed an admission date of 03/02/25. Diagnoses included PTSD, anxiety disorder, and depression. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact and was able to make her needs known. Review of the trauma evaluation dated 03/02/25 revealed Resident #20 had experienced emotional abuse from earlier in her life with triggers of being in large crowds. Symptoms due to her PTSD included difficulty sleeping, fear, severe anxiety, and feelings of guilt or shame. Triggers included large groups of people. Review of the care plan dated 05/02/24 revealed Resident #20 did not have a specific plan of care in place that addressed post-traumatic stress disorder. The care plan did not identify any triggers that may help caregivers to not be re-traumatized. Interviews with Certified Nursing Assistants #280 and #410 on 09/10/25 at 2:25 P.M. denied knowledge of specific triggers and care planning involved with post-traumatic stress disorder. Interview with the Administrator on 09/11/25 at 1:02 P.M. confirmed Resident #20's care plan did not include identified triggers that may re-traumatize Resident #20 and acknowledged that staff were not aware of this plan of care.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interview and review of facility policy the facility failed to implement pharmacy recommendations. This affected two Residents (#5 and #42) of five residents reviewed for unnecessary medications. The facility census was 53. Findings include: 1. Review of the medical record for Resident #5 revealed an admission date of 07/25/25 with diagnoses including chronic kidney disease stage three, unspecified psychosis, rheumatoid arthritis, diabetes mellitus, delusional disorder, schizoaffective disorder, major depressive disorder and malignant nodule of the lung. Review of the Medication Administration Record (MAR) dated 04/25, 05/25, 06/25, 07/25 and 08/25 revealed Resident #5 received Divalproex Sodium Sprinkles 125 milligrams (mg) by mouth, give four capsules to equal 500mg three times daily for schizoaffective disorder. Review of the pharmacy recommendations for Resident #5 dated 04/05/25 revealed Resident #5 was receiving the medication Depakote. The recommendation requested labs of complete blood count and serum Depakote level on next lab day. The physician agreed and signed the recommendation on 04/22/25. There was not a Depakote level noted in Resident #5 medical record during the month of 05/25. An interview on 09/11/25 at 8:40 A.M. with the Administrator confirmed Resident #5 had a pharmacy recommendation that was agreed upon and signed by the physician on 04/22/25 to obtain a complete blood count and a Depakote level. The Administrator confirmed Resident #5 had a complete blood count completed but no evidence of a Depakote level were noted in Resident #5 medical record. 2. Review of the medical record for Resident #42 revealed an admission date of 07/23/24 with diagnoses including hypothyroidism, chronic obstructive pulmonary disorder, Atrial fibrillation and schizophrenia. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #42 was cognitively intact. Resident #42 required assistance from the staff to complete activities of daily living. The assessment revealed Resident #42 antipsychotic medications were reviewed on routine basis with no gradual dose reduction and last physician documentation was on 03/25/25. Review of the pharmacy recommendation dated 06/24/25 with a recommendation to attempt a gradual dose reduction of Resident #42 Trazadone medication. The physician agreed to decrease the medication to 75 mg by mouth at bedtime. Review of the current physician orders dated 09/25 revealed Resident #42 had an order written on 05/30/25 for Trazadone 100 milligrams (mg) by mouth at bedtime for schizophrenia. The record did not include any information the medication was reduced as ordered by the physician on 06/24/25. An interview on 09/11/25 at 8:40 A.M. with the Administrator confirmed Resident #42 had a pharmacy recommendation that was agreed upon and signed by the physician on 06/24/25 to decrease the medication Trazadone. The Administrator confirmed Resident #42 medication was not reduced as ordered by the physician. Review of the facility policy titled Consult Pharmacist Reports effective 07/02/2021 revealed the consult pharmacist reviews each resident's medication regimen and clinical record at least monthly. The policy also stated the consultant pharmacist communicated all recommendations to those with authority and or responsibility to implement the recommendations in a timely manner.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interview, the facility failed to ensure vital signs were monitored as ordered prior to the administration of medication. This affected one resident (#2) out of the five residents reviewed for unnecessary medications. The facility census was 53. Findings include: Record review for Resident #2 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included hypertension, bipolar disorder, and depression. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/18/25, revealed the resident was assessed to have intact cognition. Review of the active physicians order, dated 11/02/24, revealed the resident was to be administered 25 milligrams of Metoprolol (an anti-hypertensive medication) twice a day for hypertension and to hold medication for pulse below 60. Review of the Medication Administration Record (MAR) and recorded vital signs from 09/01/25 through 09/11/25 revealed no evidence the residents pulse was obtained prior to the administration of Metoprolol. Interview with the Director of Nursing (DON) and Administrator on 09/11/25 at 12:35 P.M. confirmed there was no evidence Resident #2's pulse had been obtained as ordered prior to the administration of Metoprolol.		