STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366239	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Care Center of Ashland	1251 East Main Street Ashland, OH 44805

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a safe discharge for Resident #62. This affected one (Resident #62) of three residents reviewed for planned discharges. The facility census was 58.Findings include:Closed record review for Resident #62 revealed an admission date of 06/23/25 and a discharge date of 12/05/25. Diagnoses included osteomyelitis, sacral spina bifida, paraplegia, muscle weakness, cauda equina syndrome (roots of nerves form a bundle in the lowest part of the spinal column), chronic myeloproliferative disease (rare blood cancers), chronic kidney disease stage three, peripheral vascular disease, diplegia of upper limbs (a type of cerebral palsy the muscles in the arms and hands are weak or paralyzed making it difficult to perform daily activities), chronic myeloid leukemia, Arnold Chiari Syndrome (structural problem affecting the brain which can affect function and lead to various neurological challenges) with spina bifida, chronic angle closure glaucoma bilateral, type two diabetes mellitus with a foot ulcer, urinary incontinence, anxiety disorder, repeated falls, dependence on wheelchair, and a pressure ulcer. Record review of the care plan dated 06/24/25 revealed Resident #62 required assistance for activities of daily living (ADL) related to osteomyelitis, spina bifida, paraplegia, cauda equina and chronic myeloproliferative disease. The resident was totally dependent and does not participate in putting on and taking off footwear, required set up and clean up assistance for eating, oral hygiene and upper body dressing, supervision or oversight including verbal cues or encouragement for oral hygiene, personal hygiene, putting on taking off footwear, bed mobility, required weight bearing assistance including holding, lifting, or supporting trunk or limbs for lower body dressing, toilet hygiene, shower/bath self, sit-to-stand with one staff, transfer, stand pivot with one staff. Staff will assist as needed with daily hygiene and will assist with showering the resident per facility policy.Review of the care plan dated 06/26/25 revealed Resident #62 had potential for complications related to the use of catheter to urostomy stoma. Interventions included changing the urostomy catheter as needed for plugging or displacement and providing urostomy catheter care per the facility policy and as needed.Review of the care plan dated 06/25/25 revealed Resident #62 had potential for bowel and bladder elimination complications related to colostomy/urostomy. Interventions included to cleaning the stoma site and changing the dressing per orders. Teach/instruct on ostomy care techniques and allow the resident to participate at his own pace.Review of the care plan dated 06/25/25 revealed Resident #62 had actual area of skin impairment related to a pressure ulcer of sacrum. Interventions included initiating wound treatment and continuing the treatment as ordered by the medical doctor (MD). Nursing to observe the wound dressing daily to ensure that the dressing remains intact and that there are no signs or symptoms of infection or increased drainage.Review of the care plan dated 07/15/25 revealed Resident #62 had an actual area of skin impairment related to diabetic ulcer of the right foot.Interventions included initiating wound treatment and continuing the treatment as ordered by the MD. Nursing to observe the wound dressing daily to ensure that the dressing remains intact and that there are no signs or symptoms of infection or increased drainage.Review of the care plan dated 10/09/25 revealed Resident #62 had a need to collect items and refused to discard anything resulting (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in difficulty moving around safely and causing a potential fire hazard. Interventions included go through the room with the resident quarterly to clean up the clutter and move items out of room for safety reasons.Review of the progress note for Resident #62 dated 10/30/25 at 3:36 P.M. completed by Social Worker Designee (SWD) #153 revealed (Resident #62) and (Department of Developmental Disabilities ([NAME]) Care Manager) met for discharge planning today. The progress note included Resident #62 would continue the Passport Medicaid Waiver non-skilled caregiver services in the home along with services for wound care. No firm discharge date has been established at this time.Review of the progress note for Resident #62 dated 11/04/25 at 8:24 A.M. completed by Licensed Practical Nurse (LPN) #119 revealed on 11/03/25 at 10:00 A.M. Resident #62 was observed sitting on the floor between the bed and the wheelchair (w/c). Resident #62 stated, I tried to get in w/c by myself and slid off bed. Resident #62 was educated on importance of assistance with transfers. Review of the progress note for Resident #62 dated 11/24/25 at 1:19 P.M. completed by SWD #153 revealed the referral was made to Mobile Wound Care and planned to discharge home on [DATE].Review of the discharge return not anticipated Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #62 was cognitively intact. He had an indwelling catheter and an ostomy. Resident #62 required set up or clean up assistance with eating, oral hygiene, personal hygiene, partial/moderate assistance with toileting hygiene, lower body dressing, sit to stand, chair/bed to chair transfer, substantial maximal assistance with shower/bath, used a manual wheelchair and was independent for wheelchair mobility.Record review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for Resident #62 for December 2025 revealed:- An order initiated 06/24/25 for Aquaphor (a thick, petroleum-based skin protectant) to the right foot every day shift was completed by the nursing staff on 12/01/25, 12/02/25, 12/03/25 and 12/05/25. The area provided for documentation on 12/04/25 was left blank.- An order initiated 10/02/25 to change the colostomy set every three days and as needed was completed by the nursing staff on 12/01/25 and 12/04/25.- An order initiated 12/03/25 to cleanse the area to the top of the left foot second toe with normal saline/wound cleanser, pat dry, apply betadine solution (antiseptic) and leave open to air every day sift was documented as completed on 12/03/25 and 12/05/25. The area provided for documentation on 12/04/25 was left blank.- An order initiated 12/03/25 to cleanse the area to the top of the right foot with normal saline/wound cleanser, pat dry, apply betadine-soaked gauze, cover with abdominal (ABD) pad and wrap with Kerlix and secure with tape every day was documented as completed on 12/03/25 and 12/05/25. The area provided for documentation on 12/04/25 was left blank.- An order dated 11/21/25 to cleanse area to sacrum with normal saline, pat dry, apply normal saline moistened collagen sheet cover with silicone super absorbent dressing every day and night shift was completed by the nursing staff on 12/01/25, 12/02/25, 12/03/25 and 12/05/25 twice a day. The area provided for documentation on 12/04/25 from 6:00 A.M. to 6:00 P.M. was left blank.- An order dated 10/02/25 for colostomy care for every shift was documented every shift from 12/01/25 to 12/05/25 at 6:00A.M. to 6:00 P.M. as completed.- An order dated 10/02/25 for Foley catheter care every shift was documented every shift from 12/01/25 to 12/05/25 at 6:00A.M. to 6:00 P.M. as completed.- An order dated 11/21/25 for left buttocks cleanse with normal saline, apply collogen sheet followed by calcium alginate rope and cover with silicone super absorbent dressing to be done every shift (two 12-hour shifts) was documented as completed on 12/03/25 to 12/05/25 day shift. The area provided for documentation on 12/04/25 day shift was left blank.- An order dated 11/21/25 for right buttocks cleanse with normal saline, apply collogen sheet followed by calcium alginate rope and cover with silicone super absorbent dressing to be done every shift (two 12-hour shifts) was documented as completed on 12/03/25 to 12/05/25 day shift. The area provided for documentation on 12/04/25 day shift was left blank.- An order dated 10/02/25 for ostomy catheter care every shift was documented every shift from 12/01/25 to 12/05/25 at 6:00A.M. to 6:00 P.M. as completed.- An order dated 10/07/25 for transfer status stand pivot with one assist every shift was documented every shift from 12/01/25 to 12/05/25 at 6:00A.M. to 6:00 P.M. as completed.- An order dated (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/30/25 for sterile wet dressing to suprapubic site every shift was documented as completed on 12/03/25 to 12/05/25 day shift. The area provided for documentation on 12/04/25 day shift was left blank.Review of the Discharge Summary for Resident #62 dated 12/05/25 at 5:53 P.M. completed by Registered Nurse (RN) #177 revealed medications were reviewed and reconciled with the resident and his mother; discharged to home in the family car.Review of the progress note for Resident #62 dated 12/08/25 at 1:03 P.M. completed by SWD #153 revealed a telephone call from (Resident #62's) home care provider noting that there were concerns with his personal care and medication management. Further review of the closed medical record for Resident #62 revealed no documented evidence that the resident was educated on ostomy management prior to discharge, and there was no documentation to include how Resident #62's ADL needs would be met at home.Telephone interview on 04/22/26 at 4:33 P.M. with Resident #62's wife (with Caregiver #210 present) confirmed the resident was discharged home from the facility. Resident #62's wife stated, He was discharged home; it was just me; I am disabled too. Resident #62's wife revealed she and Resident #62 had a Medicaid waiver for care and services. Upon returning home from the nursing home, Resident #62 no longer had the waiver, so there was no one to help with his daily care needs. The caregiver for Resident #62's wife (Caregiver #210) revealed she was the independent provider through Medicaid Waiver for Resident #62's wife. She used to also be the caregiver for Resident #62 until he went to the nursing home and lost the waiver program. She revealed he had wound care every day at the nursing home, he went home, and the wound care nurse came once a week. The wounds became infected, and he had to go back to the hospital. The wife was blind, he gets poop on the floor, on himself, he's not able to do it, his wife is developmentally disabled, and they keep sending him home. Caregiver #210 revealed his colostomy bag kept coming off, and he got stool all over himself; she was no longer allowed to assist him because of the lost waiver, but she tells him he needs to try to wash up, and he would just throw his arms up in the air and continued sitting in the chair with stool on himself. Resident #62 was unable to bath/shower without assistance, and no one was there to assist him.Telephone interview on 04/22/26 at 512 P.M. with Resident #62's Power of Attorney (Sister) revealed Resident #62 would be safe to live at home if he had the extra help with bathing/showers and wound care. When he left the nursing home, they set up home health. They sent him home for placenta treatment for the wound. The nursing home set it up with the agency, but the wound became infected and he went back to the hospital. He wanted to go home; he did not want to be in a nursing home, but he could not shower. He had a hard time meeting his needs with colostomy care and wound care, bathing, and home health would not come daily. She stated that she did not know who was helping with the waiver, and it was not a safe discharge from the nursing home. The hospital and nursing homes send him home because he is strong willed and insists. Resident #62's Power of Attorney revealed she has been caring for grandchildren who live with her now and also cares for her [AGE] year-old mother and had not been able to go to check on Resident #62.Interview on 04/22/26 at 5:28 P.M. with SWD #153 revealed she set up home health care for Resident #62 for therapy and nursing. He elected to go with a company who provided wound care seven days a week. He had a waiver, but he lost it. His wife had the same worker coming in the home from the waiver he used to have, so, she felt it was a safe discharge. Interview on 04/23/26 at 11:00 A.M. with the Administrator confirmed Resident #62 did not have the level one waiver available when he discharged home.Interview on 04/23/26 at 11:37 A.M. with SWD #153 revealed on 10/30/26, she did believe Resident #62 still had his waiver, it was learned later, before discharge, the waiver was lost. The support person was to reapply for the waiver with him. SWD #153 revealed his mom would have been able to take care of him. SWD #153 was informed that his mom was [AGE] years old, and Resident #62's sister (Power of Attorney) also cared for his mom.Review of the email dated 04/23/26 at 11:38 A.M. from the Home Health Company that was set up to be initiated upon discharge by SWD #153 for Resident #62 (sent to the facility Administrator) revealed they did a start of care for Resident #62 on 10/09/25. They provided skilled nursing two times a week to monitor the foot ulcer with dressing change. Resident #62 had a third party wound (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	specialist that managed the buttocks wound. The Home Health Company did not provide a home health aide. The Home Health referral orders were for skilled nursing/physical therapy/occupational therapy. The resident was readmitted to the hospital on [DATE]. The resident's wife was the primary caregiver and was able to care for the wounds, diabetes management, etc.Interview on 04/23/26 at 12:43 P.M. with LPN #137 confirmed she remembered Resident #62 stating, he would do a lot, but as far as being able to bathe or clean up, he needed help, and he needed help with his ostomies. He was a picker, he kept messing with the bags and ostomies, so we had to change them multiple times a day for him. LPN #137 revealed she never provided education or observed Resident #62 provide any care for himself prior to discharge.Interview on 04/23/26 at 12:53 P.M. with LPN #118 revealed Resident #62 was at risk for falls and required assistance with transfers due to his falls. LPN #118 revealed she never educated Resident #62 on any care or medications. She would cut the shapes for both his ostomies, and he would apply them. The nurses always administered his medications and provided his care. He needed help with bathing transfers, meal set up, and cleaning himself up.Interview on 04/23/26 at 1:03 P.M. with Certified Nursing Assistant (CNA) #165 revealed she cared for Resident #62 when he resided at the facility. Resident #62 required assistance with transfers; she would stand and pivot him to the chair. He needed help to get washed up; he needed a lot of help to get bathe. The nurses did the dressing changes to his wounds and administered his medications, and he needed someone to set up his meals.This deficiency represents non-compliance investigated under Complaint Number 2679689.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interviews, facility policy review, and review of the 2025 International Pressure Injury Guidelines, the facility did not follow appropriate infection control practices during wound care and failed to provide or offer an appropriate pressureˆreducing mattress to support healing of a pressure ulcer. This failure affected one resident (Resident #26) of three residents reviewed for wound care. The facility census was 58.Findings include: Record review for Resident #26 showed admission on [DATE], discharge on [DATE], readmission on [DATE], discharge on [DATE], and readmission on [DATE]. Diagnoses included a Stage IV pressure ulcer and muscle weakness. A Stage IV ulcer involves fullˆthickness tissue loss with exposed bone, tendon, or muscle, and may include slough, undermining, or tunneling.Review of the care plan dated 07/25/25 indicated an actual skin impairment to the sacrum related to pressure. Interventions included initiating wound treatment, continuing treatment as ordered, and providing a pressureˆreducing mattress.Review of the Discharge Return Anticipated MDS 3.0 (03/10/26) documented that Resident #26 had intact memory, was independent with cognitive decisionˆmaking, and had one Stage IV pressure ulcer that was present upon admission.Physician orders dated 04/11/26 directed daily wound care to the sacrum: cleanse with wound cleanser, pat dry, lightly pack with normalˆsaline-moistened collagen, and cover with a silicone superˆabsorbent dressing.The Weekly Skin Grid Pressure report dated 04/21/26 at 4:47 P.M. documented a sacral Stage IV ulcer first identified on 07/18/25. The wound exhibited fullˆthickness tissue loss with exposed bone, tendon, or muscle; slough or eschar in portions of the wound bed; and scant lightˆpink drainage. The ulcer had not healed.Observation on 04/22/26 at 2:15 P.M. of Registered Nurse (RN)/Wound Care Nurse #127 providing wound care with Assistant Director of Nursing (ADON) #155 present. Resident #26 requested care while standing with a walker for support. The resident was observed on a standard facility mattress with a visible indentation where the resident's buttocks rested. RN/Wound Care Nurse #127 removed the old dressing, cleansed the wound with cleanser and 4x4 gauze, packed the wound with salineˆmoistened collagen, and applied a new dressing. At no point during the procedure did she wash her hands or use hand sanitizer. Although she changed gloves, she did not perform hand hygiene between steps.During an interview at the time of the observation, both RN/Wound Care Nurse #127 and ADON #155 confirmed that Resident #26 did not have an appropriate pressureˆreducing mattress, such as a lowˆairˆloss mattress, which is indicated for a Stage IV pressure injury. They acknowledged the visible indentation in the mattress and could not explain why a lowˆairˆloss mattress had not been offered. ADON #155 stated she would obtain one. In addition, Resident #26 reported discomfort from sinking into the mattress and stated he had never been offered a lowˆairˆloss mattress.The 2025 International Pressure Injury Guideline (NPIAP/EPUAP/PPPIA, 4th Edition) identifies lowˆairˆloss mattresses as a reactive support surface recommended for Stage IV pressure injuries. These surfaces provide pressure redistribution and microclimate management and are recognized as integral components of pressure injury management. Evidence, including a 2023 systematic review, indicates that airˆbased support surfaces improve healing conditions by offloading pressure, reducing friction and shear, managing moisture and heat, and supporting an optimal healing microenvironment.The facility's Clean Dressing Change policy (dated 06/01/24) requires staff to remove the existing dressing, remove gloves, perform hand hygiene, don clean gloves, cleanse and dry the wound, then again perform hand hygiene and don new clean gloves before applying the ordered dressing. RN/Wound Care Nurse #127 did not follow these handˆhygiene steps.This deficiency represents non-compliance investigated under Complaint Number 2646034.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the insulin pen instruction manual, the facility failed to administer insulin to Resident #12 per the physician order. This affected one (Resident #12) of two residents observed for insulin administration. The facility census was 58.Findings include:Record review for Resident #12 revealed an admission date of 10/29/25. Diagnoses included type two diabetes mellitus with diabetic chronic kidney disease and muscle weakness. Review of the care plan dated 10/29/25 revealed Resident #12 had potential risk for hyper/hypoglycemia due to diagnosis of diabetes. Interventions included administering medications per physician's order.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #12 was mildly cognitively impaired, required assistance with activities of daily living, and received hypoglycemic medication (including insulin) and insulin injections daily. Review of the physician order dated 04/20/26 revealed an order for NovoLog flex pen subcutaneous solution pen injector 100 units (u) per milliliter (ml) inject two u subcutaneously before meals related to type two diabetes mellitus. Hold dose for blood sugar below 70.Observation on 04/22/26 at 8:35 A.M. during medication administration for Resident #12 revealed Licensed Practical Nurse (LPN) #109 removed Resident #12's NovoLog flex pen from the medication cart and applied the needle. She then dialed the flex pen to two units; LPN #109 did not prime the flex pen. Upon entering the room, Resident #12 was sitting up in bed. The staff had already removed Resident #12's breakfast tray. LPN #109 stated Resident #12 finished her breakfast at around 8:30 A.M. Resident #12 stated she ate 100% of her breakfast. LPN #109 administered the two units of insulin to Resident #12 subcutaneously and returned to the medication cart. She confirmed Resident #12's insulin was administered after breakfast and confirmed she did not prime the insulin pen and stated, I only prime the insulin pens when they are new, I broke too many pens trying to prime them. LPN #109 revealed she would dial the pen forward then when she forced the dial back to zero to prime it, the pen would break, so she stopped priming them. Interview with the Director of Nursing (DON) on 04/22/26 at 2:57 P.M. revealed insulin pens were to be primed before each use.Review of the progress note for Resident #12 dated 04/22/26 at 3:43 P.M. completed by Assistant Director of Nursing (ADON) #155 revealed Resident #12's lunch blood sugar was 198 with a re-check of 202. Review of the Medication Administration Record (MAR) revealed routine blood sugar results were not documented.Review of the undated insulin pen instruction manual titled, Instruction for use for NovoLog insulin pens for use guidance revealed to attach a new needle to the pen. Always do a safety test (Priming) before each injection to check your pen and the needle to make sure they are working properly and to make sure you get the correct insulin dose. Select two units by turning the dose selector until the dose pointer is at the two mark, press the injection button all the way in, when insulin is coming out of the needle tip, your pen is working correctly. If no insulin appears, you may need to repeat this step up to three times before seeing insulin. If no insulin comes out after the third time the needle may be blocked. If this happens change the needle and repeat the safety check. After the safety check is complete, select the dose to administer.This deficiency represents non-compliance investigated under Complaint Number 2646034.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview and review of the manufacturer instructions for the facility glucometers, the facility failed to ensure staff maintained proper infection control practices while using glucometers. This affected two (Residents #12 and #41) of two residents blood sugar assessments observed and had the potential to affect an additional seven (Residents #3, #5, #24, #40, #41, #43, #44 and #58) identified by the facility as also receiving blood sugar monitoring via glucometer. The facility census was 58.Findings include:1. Record review for Resident #12 revealed an admission date of 10/29/25. Diagnoses included type two diabetes mellitus with diabetic chronic kidney disease and muscle weakness.Review of the care plan dated 10/29/25 revealed Resident #12 had potential risk for hyper/hypoglycemia due to diagnosis of diabetes. Interventions included obtaining blood sugar levels as ordered.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #12 was mildly cognitively impaired, required assistance with activities of daily living, received hypoglycemic medication (including insulin) and received insulin injections daily. Review of the physician order dated 04/20/26 revealed an order for NovoLog flex pen subcutaneous solution pen injector 100 units per milliliter (ml) inject two units subcutaneously before meals related to type two diabetes mellitus. Hold dose for blood sugar below 70.Observation on 04/22/26 at 8:35 A.M. of Licensed Practical Nurse (LPN) #109 complete a fingerstick blood sugar assessment on Resident #12 prior to insulin administration revealed LPN #109 removed the glucometer from the top drawer of the medication cart. The glucometer was uncovered and lying on top of lancets. No other glucometers were visibly present. LPN #109 entered Resident #109's room, did not clean the glucometer, assessed Resident #109's blood sugar via fingerstick with use of the glucometer then returned to the medication cart. LPN #109 revealed there was one glucometer on her medication cart used for all the residents who received blood sugar finger sticks on her assignment. LPN #109 then revealed she did not clean the glucometer on day shift because night shift cleans them. After being questioned about cleaning the glucometer, LPN #109 then took an alcohol wipe and wiped the front and back of the glucometer off lasting less than five seconds then returned the glucometer back to the medication cart.2. Record review for Resident #41 revealed an admission date of 12/02/22. Diagnoses included diabetes mellitus due to underlying conditions with hyperosmolarity and weakness.Review of the care plan dated 12/03/22 revealed Resident #41 had potential risk for hypo/hyperglycemia related to diagnosis of diabetes. Interventions included obtaining blood sugar levels as ordered.Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #41 was cognitively intact. Resident #41 required assistance with activities of daily living and received insulin injections daily.Review of the physician orders for Resident #41 revealed an order for Humalog Kwik pen subcutaneous solution pen injector 100 units per ml inject six units subcutaneous before meals related to type two diabetes mellitus, hold if blood sugar is less than 100.Observation on 04/22/26 at 11:25 A.M. of LPN #205 complete a fingerstick blood sugar assessment on Resident #41 prior to insulin administration revealed LPN #205 removed the glucometer from the top drawer of the medication cart. The glucometer was uncovered and lying on top of lancets. No other glucometers were visibly present. LPN #205 wiped the glucometer off with an alcohol wipe, entered Resident #41's room and assessed her blood sugar via fingerstick with use of the glucometer. After returning back to the medication cart, LPN #205 wiped the glucometer off with an alcohol wipe for less than seven seconds and wrapped the glucometer with dry tissue. LPN #205 verified the glucometer was used for all residents who received fingerstick blood sugars on that assignment.Interview and observation of medical supplies available on 04/23/36 at 1:08 P.M. with Assistant Director of Nursing (ADON) #155 revealed Super Sani Germicidal Disposable wipes were to be used to clean the facility glucometers.Review of the Manufacturer's instructions for the facility used glucometers revealed, Cleaning and Disinfecting the Assure Prism multi-Blood Glucose (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Care Center of Ashland	1251 East Main Street Ashland, OH 44805

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitoring System revised 03/01/23 revealed to minimize the risk of transmitting blood borne pathogens, the cleaning and disinfecting procedure should be performed as recommended in the instructions. The instructions for use of Super Sani Germicidal Disposable wipes included the meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent transmission of blood borne pathogens. With the use of Super Sani Germicidal Disposable wipes the cleaning procedure included wiping the entire surface of the glucometer three times horizontally and three times vertically using one towelette to clean blood and other body fluids. Dispose the towelette in the trash can. Disinfecting included pulling one new towelette and wiping the entire surface of the glucometer three times horizontally and three times vertically to remove blood-borne pathogens. Dispose the towelette in the trash bin. Allow exterior to remain wet for two minutes then wipe the meter using a dry cloth. The recommended cleaning and disinfectants that were acceptable for use in cleaning the glucometer between resident use did not include use of alcohol wipes.The deficiency was an incidental finding observed during the complaint investigation.