

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033</p> <p>Based on medical record review, review of electronic communications (e-mail), staff interview and review of facility policy, the facility failed to ensure a request for medical records was addressed timely. This affected one (#270) of one resident reviewed for medical record requests. The facility census was 59.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #270 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses include altered mental status, psychosis, encephalopathy, anxiety, restlessness and agitation, depression, sepsis, hypertension, and a history of cerebral infarction.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment.</p> <p>Review of an e-mail, dated 03/07/25 at 4:08 P.M., revealed Resident #270's family member requested the resident's medical records from the facility. Further review of an e-mail dated 03/14/25 at 2:15 P.M., revealed Resident #270's family member sent another email following up on the previous request for the resident's medical records. There was no response from the facility informing the family member of the process for requesting medical records.</p> <p>Interview on 04/29/25 at 10:36 A.M. with Social Service Designee (SSD) #425 revealed a form must be completed to request medical records and then given to the Administrator. SSD #425 revealed she could not recall receiving a request for medical records for Resident #270.</p> <p>A follow-up interview on 04/29/25 at 3:40 P.M. with SSD #425 confirmed the family of Resident #270 had sent e-mails on 03/07/25 and 03/14/25 requesting medical records. SSD #425 revealed she returned from vacation on 03/17/25 and must have missed the e-mails requesting medical records from Resident #270's family. SSD #425 stated she would follow-up with the family and expedite the request.</p> <p>Interview on 04/30/25 at 7:45 A.M. with the Administrator revealed he had not been notified of a request for medical records for Resident #270.</p> <p>(continued on next page)</p>

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: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility policy titled, Release of Medical Records, dated 06/01/24, revealed requests for records should be referred to the Director of Nursing, Administrator, or another staff member previously designated by the facility. After receiving a request, the facility would notify the requesting party of the cost to obtain the records and would provide the records within two days after receipt of payment for the copies.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164819.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>44454</p> <p>Based on observation, resident interview, staff interview, and policy review, the facility failed to maintain a comfortable, clean, sanitary, and homelike environment that was in good repair. This affected four (#40, #30, #48 and #22) of four residents reviewed for the environment with the potential to affect and additional 23 residents (#3, #8, #10, #16, #17, #20, #24, #26, #27, #28, #34, #41, #42, #43, #47, #54, #57, #59, #319, #320, #321, #322, #323) residents who resided on the 300-unit. The facility census was 59.</p> <p>Findings include:</p> <p>1. Observation on 04/28/25 at approximately 10:10 A.M. revealed a door was located at the far end of the 300-hall, past the nursing station. There was a gap between the bottom of the door and the door frame, through which the outside could be seen.</p> <p>Interview on 04/28/25 at approximately 10:15 A.M. with Resident #40 revealed the resident could often feel the elements of the weather because of the gap between the door and the doorframe. Resident #40 reported she could feel the heat and cold air coming in, she worried about insects getting in, and it was especially drafty and uncomfortable in the winter time.</p> <p>Interview on 04/30/25 at approximately 9:13 A.M., Registered Nurse (RN) #585 verified the gap between the bottom of the door and the door frame, allowing the outside elements into the facility.</p> <p>2. Observation on 04/28/25 at 9:42 A.M. of Resident #30's room revealed the window air conditioning unit was not properly installed, leaving a space open to the outdoors. Coinciding interview with Resident #30 revealed she believed spiders and insects were coming in through her window where the window air conditioning unit was not properly installed and open to the outdoors.</p> <p>Interview on 05/01/25 at 08:37 A.M. with the Director of Maintenance (DM) #880 verified the window air conditioning unit was not properly installed and left a space open to the outdoors.</p> <p>3. Observation on 05/01/25 at 10:30 A.M. of the shower room located on the 300-unit revealed the following:</p> <p>There were numerous broken tiles surrounding the drain in the shower area.</p> <p>There was a blood-soaked item located on the floor to the right of the toilet.</p> <p>There was a dried red substance on the wall behind the toilet.</p> <p>There were numerous scuffed, scraped, and chipped areas on the door.</p> <p>An interview on 05/01/25 at 10:36 A.M. with Certified Nursing Assistant (CNA) #500 verified the above findings.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Observation on 04/28/25 at 11:04 A.M. of Resident #48 and Resident #22's bathroom revealed the baseboard was not attached to the bathroom wall on the side of the toilet and sink. Further observation of the room revealed the wall behind Resident #48's recliner had a large are with the paint scrapped off and food particles scattered on the floor.</p> <p>Interview on 04/29/25 at 10:05 A.M. with Registered Nurse (RN) #345 confirmed the unattached baseboard in Resident #48 and Resident #22's bathroom, the paint scraped off the wall behind Resident #48's recliner, and the food particles scattered on the floor.</p> <p>Review of the facility policy titled, Resident Environmental Quality, dated 11/29/22, revealed the facility should have a sanitary and comfortable environment for residents, staff, and the public.</p> <p>Review of the facility policy titled Resident Rights, dated 06/01/24, revealed residents had the right to a safe, clean, comfortable, and homelike environment.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00165111 and Complaint Numbers OH00164819 and OH00164408.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on medical record review, resident interview, staff interview, Nurse Practitioner (NP) interview, review of hospital records, and review of facility policy, the facility failed to adequately monitor Resident #271's cellulitis (potentially serious bacterial skin infection), failed to timely identify a change in condition, and further failed to notify the physician of the resident's decline. This resulted in actual harm for Resident #271 on 03/29/25 when the facility failed to adequately monitor the resident's right lower extremity cellulitis to identify a worsening of the condition and, therefore, did not notify the physician of the decline. Resident #271's family member intervened and requested the facility transfer the resident to the hospital for further evaluation and treatment. Subsequently, Resident #271 was admitted to the hospital and treated with intravenous (IV) antibiotics due to a deterioration of the condition. Additionally, the facility failed to provide interventions for constipation for Resident #16 and further failed to implement heel protection devices per physician order for Resident #323 that placed the residents at potential for more than minimal harm that was not harm. This affected three (#271, #16 and #323) of three resident reviewed for quality of care and treatment. The facility census was 59.</p> <p>Findings include:</p> <p>1. Review of Resident #271's closed medical record revealed an admitted [DATE]. Diagnoses included fracture of the right tibia, atrial fibrillation, chronic obstructive pulmonary disease (COPD), and cellulitis. The resident transferred to the hospital on 03/29/25 and discharged from the facility on 03/30/25.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 01/21/25, revealed Resident #271 required substantial staff assistance with all activities of daily living (ADLs).</p> <p>Review of the care plan, initiated 01/20/25, revealed Resident #271 had a potential for alteration in skin integrity.</p> <p>Review of the Certified Nurse Practitioner (CNP) progress note, dated 03/28/25, revealed Resident #271 was seen for a follow up visit by CNP #710 due to right leg redness due to a skin tear found the previous day. Per staff, the skin tear was observed on 03/27/25 and was cleaned and covered. Staff stated on 03/28/25, the resident's right lower leg was red, and that was a new finding. The resident complained of some pain with palpitation of the lower right leg but denied any chest pain or shortness of breath. Per nursing, vital signs were stable and no other concerns or findings were reported. Further review revealed CNP #710's assessment included a diagnosis of cellulitis with new redness to the lower right leg from the ankle to the knee. There was mild warmth and pain present with palpation. The resident did not have a fever and no additional changes were noted. Doxycycline (antibiotic) 100 milligrams (mg) was ordered. Additional orders included monitoring the skin and the resident's progress and call the CNP or medical physician if fever increased, redness with streaking, increased pain, or changes in vital signs were observed.</p> <p>Review of a health status note, dated 03/29/25, revealed the nurse spoke to Resident #271's daughter and informed her of the cellulitis and skin tear. The resident's daughter was very upset that she was not informed about the resident's worsening skin condition.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Further review of Resident #271's medical record revealed no evidence the resident's skin condition was monitored until 03/29/25 at 7:30 P.M. when the resident's daughter brought her concerns to the attention of staff and the resident was subsequently transported to the hospital per family request.</p> <p>Review of Resident #271's nursing observations dated 03/29/25 revealed the resident's daughter visited at approximately 7:30 P.M. and asked the nurse to send the resident to the hospital to be evaluated properly. At the time, Resident #271 was on antibiotic therapy for right lower leg cellulitis.</p> <p>Review of the hospital notes, dated 03/29/25, revealed Resident #271 was brought to the emergency room (ER) due to an infection of the right lower extremity. Symptoms began on 03/27/25 and the resident was started on Doxycycline on 03/28/25. The daughter went to visit the resident and she was concerned because the dressing on the right lower extremity was too tight and the infection was spreading up to the proximal (area from the hip to the knee) leg. There were photos of the right leg in the system. There was cellulitis involving the anterior tibia (front, outer area of the leg) and also the medial aspect (inner part, located between the hip and the knee) of the thigh and across the buttocks, which appeared to be erythematous (abnormal redness) rash concerning for cellulitis as well. The resident had a previous history of stroke and a right hip fracture per the daughter. The daughter did not want the resident to return to the facility she came from.</p> <p>Further review of the hospital notes revealed Resident #271's lower right leg was tender with 2+ pitting edema (indicating a moderate amount of fluid buildup in the tissue) present. The leg had erythema (redness) present. The resident had diffuse edema of the right lower extremity with diffuse patchy areas of erythema with mild increase in temperature. There was also an area of erythema on the medial thigh. The resident had a lot of tenderness with palpation of the right lower extremity. The resident was admitted to the hospital and started on IV antibiotics. Additional review of the hospital records revealed photographs were taken on 03/29/25, upon arrival to the ER, and revealed the cellulitis had migrated up the resident's inner thigh and onto her buttocks.</p> <p>Interview with Licensed Practical Nurse (LPN) #913 on 04/30/25 at 4:40 P.M. revealed she cared for Resident #271 on 03/29/25. LPN #913 stated she informed the Infection Control Nurse (ICN) that the resident's cellulitis was weeping fluids. At that time, a mesh sleeve was applied by both nurses, with no other intervention or notification made to the physician. LPN #913 stated that at approximately 12:00 P.M., Resident #271's daughter arrived at the facility and was extremely upset because staff had failed to inform her of the resident's worsening cellulitis. Resident #271's daughter left and returned later in the day and requested the resident be transferred to the hospital for evaluation.</p> <p>Interview with CNP #710 on 05/01/25 at 10:55 A.M. verified she had not been notified of Resident #271's worsening cellulitis until the resident was transferred to the hospital by request of the family. CNP #710 reviewed the photographs taken at the time of Resident #271's admission to the hospital of the worsening cellulitis and stated that had the resident been in that condition when she saw her on 03/28/25, she would have sent her to the hospital immediately.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility policy titled, Notification of Changes, revised 01/01/25, revealed the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Further review revealed circumstances requiring notification included significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include life-threatening conditions or clinical complications.</p> <p>2. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included end stage renal disease, chronic pain syndrome, and type II diabetes mellitus.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/17/24, revealed Resident #16 was cognitively intact. The resident was always continent of urine and occasionally incontinent of bowel.</p> <p>Review of the physician orders revealed Resident #16 had an order dated 04/19/25 for lactulose oral solution, give 30 milliliters (ml) by mouth every 24 hours as needed for constipation.</p> <p>Review of the plan of care dated 04/21/25 revealed Resident #16 was at risk for alteration in bowel elimination and constipation. Interventions included administering laxatives, stool softeners, or other bowel medications as ordered. Additionally, if no bowel movement (BM) within three days, begin bowel evacuation protocol per facility policy.</p> <p>Review of Resident #16's bowel tracking log from 04/10/25 through 04/30/25 revealed no documented BMs between 04/25/25 through 04/28/25.</p> <p>Review of the Medication Administration Record (MAR) from 04/19/25 through 04/30/25 revealed the lactulose was not administered to the resident during this time period.</p> <p>Interview on 05/01/25 at 3:04 P.M. with the Administrator verified the bowel tracking log log indicated Resident #16 did not have a BM from 04/25/25 through 04/28/25 and further confirmed there was no evidence interventions for constipation were offered or administered to the resident.</p> <p>Review of the facility policy titled, Routine Bowel Regimen, dated August 2018, revealed the BMs of residents were monitored. The policy stated that if a resident did not have a BM for three days, a nurse would assess and notify the physician if any issues were identified. Residents who were determined to have a typical bowel movement schedule other than three days, would implement the bowel movement protocol relevant to their personal routine. Unless the physician had given a different order, a laxative would be administered.</p> <p>3. Review of the medical record revealed Resident #323 was admitted to the facility on [DATE]. Diagnoses included atherosclerosis of native arteries of extremities with gangrene, hypertension, end stage renal disease, type II diabetes mellitus, and hyperkalemia.</p> <p>Review of the admission MDS assessment, dated 04/09/25, revealed Resident #323 was cognitively intact.</p> <p>Review of the hospital discharge records, dated 04/09/25, revealed Resident #323's discharge instructions included Prevalon boots (heel protectors) on when in bed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the physician orders revealed an order dated 04/14/25 for Resident #323 to have Prevalon boots on while in bed.</p> <p>Observation on 04/28/25 at 10:30 A.M. revealed Resident #323 was in bed and was not wearing Prevalon boots.</p> <p>Interview on 04/28/25 at 11:28 A.M. with Certified Nursing Assistant (CNA) #610 verified Resident #323 did not have Prevalon boots or any type of heel protectors on while in bed. CNA #610 reported the resident never had Prevalon boots since admitting to the facility.</p> <p>Observation on 04/29/25 at approximately 4:15 P.M. revealed Resident #323 was in bed and did not have Prevalon boots on.</p> <p>Interview on 04/29/25 at approximately 4:17 P.M. with Resident #323 revealed he never had Prevalon boots or any type of heel protector since admitting to the facility. Resident #323 reported he would wear them if he had them.</p> <p>Observation on 04/30/25 at 9:30 A.M. revealed Resident #323 was in bed and did not have Prevalon boots on.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00164819 and OH00164408.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on observation, resident interview, staff interview, medical record review and review of facility policy, the facility failed to ensure wound care recommendations for an alternating air/low air loss mattress were implemented to prevent the development of pressure ulcers. This affected on (#53) of three residents reviewed for pressure ulcers. The facility census was 59.</p> <p>Findings included:</p> <p>Review of Resident #53's medical record revealed an admitted [DATE]. Diagnoses included lymphedema, chronic kidney disease, and obstructive uropathy.</p> <p>Review of Resident #53's quarterly Minimum Data Set (MDS) assessment, dated 01/14/25, revealed the resident had an intact cognition. The resident required substantial/maximal staff assistance to roll left and right in bed and had impairments on both sides of his lower extremities.</p> <p>Review of Resident #53's care plan revealed he was at risk for alteration in skin integrity. Interventions included a pressure reducing mattress on his bed to promote comfort and prevent skin breakdown.</p> <p>Review of Resident #53's Braden Scale (assessment to determine pressure ulcer risk), dated 03/17/25, revealed he was at a low risk for the development of pressure ulcers.</p> <p>Review of Resident #53's wound care progress notes dated 03/11/25 revealed the resident was seen for incontinence associated dermatitis of the sacrum and a skin tear to the lower leg. The resident was noted to have a history of a chronic wound and pressure ulcer. Further review revealed Resident #53 was to be on an alternating pressure/low air loss mattress for pressure redistribution and ensure settings were maintained at an appropriate level based on the resident's needs and body habitus. Resident #53 was noted to be at high risk for pressure ulcer formation related to decreased mobility, incontinence of urine and stool, and declining turning and repositioning.</p> <p>Review of a wound care progress note dated 04/01/25 revealed the incontinence associated dermatitis of the sacrum was healed. Resident #53 was noted to have a history of a chronic wound and pressure ulcer. Further review revealed Resident #53 was to be on an alternating pressure/low air loss mattress for pressure redistribution and ensure settings were maintained at an appropriate level based on the resident's needs and body habitus. Resident #53 was noted to be at high risk for pressure ulcer formation related to decreased mobility, incontinence of urine and stool, and declining turning and repositioning.</p> <p>Observation on 04/28/25 at 11:00 A.M. revealed Resident #53 was in bed. The resident did not have an alternating pressure/low air loss mattress. Concurrent interview with Resident #53 revealed he did not get out of bed very often. The resident stated he did not have a special mattress (alternating pressure/low air loss mattress).</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/28/25 at 11:21 A.M. with Certified Nursing Assistant (CNA) #820 and Licensed Practical Nurse (LPN) #370 verified Resident #53 did not have an alternating pressure/low air loss mattress in place as recommended by wound care.</p> <p>Review of the facility policy titled, Pressure Injury Prevention and Management, revised 01/08/25, revealed the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury Additionally, to facility was committed to prevent infection and the development of additional pressure ulcers/injuries. The unit manager, or designee, will review skin assessments, progression towards healing, and compliance at least weekly and document a summary of findings in the medical record.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on medical record review, staff interview and review of facility policy, the facility failed to ensure physician ordered catheter care was provided. This affected three (#53, #48 and #22) of six residents reviewed for catheter care. The facility census was 59.</p> <p>Findings included:</p> <p>1. Review of Resident #53's medical record revealed an admitted [DATE]. Diagnoses included lymphedema, chronic kidney disease, and obstructive uropathy.</p> <p>Review of Resident #53's quarterly Minimum Data Set (MDS) assessment, dated 01/14/25, revealed the resident had intact cognition. Additionally, the resident had a suprapubic catheter.</p> <p>Review of Resident #53's care plan revealed he was at risk for complications related to the use of a suprapubic catheter. Resident #53 would have no signs and symptoms of a urinary tract infection (UTI) or complications related to suprapubic catheter use. Interventions included to assist with suprapubic catheter care.</p> <p>Review of the physician orders revealed an order dated 01/14/25 to complete suprapubic catheter care every shift and an order dated 04/04/25 to apply a clean four by four (4 x 4) gauze to the suprapubic site daily.</p> <p>Review of the Treatment Administration Record (TAR) for March 2025 revealed no documentation Resident #53's suprapubic site was cleaned and the gauze was changed on 03/06/25, 03/20/25, 03/22/25, and 03/27/25. Further review of the TAR for April 2025 revealed no evidence the treatment was completed on 04/02/25, 04/06/25, 04/08/25, 04/09/25, 04/14/25, 04/15/25, 04/18/25, 04/19/25, 04/20/25, 04/24/25, 04/28/25, and 04/29/25.</p> <p>Additional review of the TAR revealed no evidence suprapubic catheter care was provided for Resident #53 on the day shift on 04/03/25, 04/06/25, 04/08/25, 04/09/25, 04/14/25, 04/15/25, 04/19/25, 04/20/25, 04/24/25, 04/28/25, and 04/29/25. Further review revealed no documentation care was provided on the night shift on 04/08/25, 04/09/25, and 04/30/25.</p> <p>Interview on 04/30/25 at 11:25 A.M. with Resident #53 revealed staff failed to cleanse and change the dressing to his suprapubic catheter daily. Resident #53 stated there were times when several days would pass between dressing changes.</p> <p>Interview on 05/01/25 at 11:22 A.M. with Infection Control Preventionist (ICP) #310 and MDS Nurse #710 confirmed treatments were not documented as completed for Resident #53's suprapubic catheter care and dressing changes.</p> <p>51528</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus and obstructive and reflux uropathy.</p> <p>Review of the quarterly MDS assessment, dated dated 03/31/25, revealed Resident #48 was cognitively intact and had an indwelling urinary catheter.</p> <p>Review of a physician order dated 09/30/24 revealed Resident #48 had an order for indwelling urinary catheter care every shift.</p> <p>Review of the Treatment Administration Record (TAR) for April 2025 revealed Resident #48's catheter care was not documented as provided on the 6:00 A.M. to 6:00 P.M. shift on 04/04/25, 04/06/25, 04/09/25, 04/10/25, 04/19/25, and 04/20/25. Further review revealed no evidence the care was provided on the 6:00 P. M. to 6:00 A.M. on 04/23/25.</p> <p>Interview on 04/30/25 at 9:18 A.M. with Registered Nurse (RN) #345 confirmed catheter care was not documented as completed for Resident #48 on the 6:00 A.M. to 6:00 P.M. shift on 04/04/25, 04/06/25, 04/09/25, 04/10/25, 04/19/25, and 04/20/25 and on the 6:00 P.M. to 6:00 A.M. shift on 04/23/25.</p> <p>3. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type II, peripheral vascular disease, and congestive heart failure.</p> <p>Review of the quarterly MDS assessment, dated 03/10/24, revealed Resident #22 had mild cognitive impairment and had a suprapubic catheter.</p> <p>Review of a physician order dated 01/14/25 revealed Resident #22 had and order for suprapubic catheter care every day shift. Further review revealed an order dated 03/08/25 for Mupirocin (treats bacterial infections) external ointment two percent (%), apply to surrounding skin of catheter topically two times a day for suprapubic catheter care.</p> <p>Review of the TAR for April 2025 revealed there was no documentation that suprapubic catheter care was provided on 04/19/25 and 04/20/25. Further review revealed there was no documentation that Mupirocin ointment was applied to the skin surrounding the resident's catheter upon rising on 04/19/25, 04/20/25, 04/24/25, and 04/29/25 and on the 6:00 P.M. to 6:00 A.M. shift on 04/23/25.</p> <p>Interview on 04/30/25 at 9:18 A.M. with RN #345 confirmed catheter care was not documented as completed for Resident #48 on the 6:00 A.M. to 6:00 P.M. shift on 04/04/25, 04/06/25, 04/09/25, 04/10/25, 04/19/25, and 04/20/25 and on the 6:00 P.M. to 6:00 A.M. shift on 04/23/25. Further interview with RN #345 verified Resident #22's suprapubic catheter care was not documented as completed on 04/19/25 and 04/20/25 and Mupirocin ointment was not documented as completed upon rising on 04/19/25, 04/20/25, 04/24/25, and 04/29/25 and on the 6:00 P.M. to 6:00 A.M. shift on 04/23/25.</p> <p>Review of the facility policy titled, Catheter Care, dated 06/01/24, revealed catheter care would be performed every shift and as needed by nursing personnel.</p> <p>Review of the facility policy titled, Suprapubic Catheterization, dated 06/01/24, revealed suprapubic catheters would be changed in accordance with current standards of practice to minimize risk for bacterial contamination or failed insertions. The care and maintenance of suprapubic catheters shall be in accordance with physician's orders.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on medical record review, observation, staff interview, visitor interview, and review of facility policies, the facility failed to obtain physician orders to ensure a percutaneous endoscopic gastrostomy (PEG) tube was monitored and cared for appropriately. This affected one (#28) of one resident reviewed for tube feedings. The facility census was 59.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #28 was admitted to the facility on [DATE]. Diagnoses included dysphagia, muscle weakness, anemia, ileus, and hypertension.</p> <p>Review of the admission Minimum Data Set (MDS) assessment, dated 01/23/25, revealed Resident #28 was severely cognitively impaired and had a feeding tube.</p> <p>Review of the plan of care, dated 01/21/25, revealed Resident #28 had the potential for alteration in skin integrity. Interventions included cleansing the area around the PEG tube site as ordered and as needed, apply dressing, inspect the skin around the PEG tube daily for redness/drainage/breakdown, and observe the PEG tube site for signs and/or symptoms of infection and obtain vital signs to check for temperature elevations.</p> <p>Review of the physician orders for April 2025 revealed Resident #28 had no orders to cleanse, inspect, or observe the area around the resident's PEG tube or to apply a dressing. There was a previous order dated 01/18/25 to cleanse PEG tube with normal saline and apply clean dry dressing daily and as needed every day and night shift. The previous order did not indicate what type of dressing was needed.</p> <p>Review of the Treatment Administration Record (TAR) for April 2025 revealed no documentation related to staff inspecting or observing the resident's PEG tube site. There was also no documentation staff had been cleansing the resident's PEG tube site or that a dressing had been applied or in place from 04/10/25 through 04/29/25.</p> <p>Interview on 04/28/25 at 3:00 P.M. with Resident #28's visitor, who reported visiting the resident daily Monday through Friday, revealed the visitor observed Resident #28's PEG tube with dried blood around it on the previous Thursday (04/24/25). The visitor reported they informed a staff member, who never returned to clean it. The visitor also reported there had been no dressing on the PEG tube site.</p> <p>Observation on 04/29/25 at 9:57 A.M. with Licensed Practical Nurse (LPN) #370 revealed Resident #28's PEG tube site had a split gauze dressing dated 04/29/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/29/25 at 10:40 A.M. with LPN #370 verified there were no physician orders for the care of Resident #28's PEG tube, including dressings, observing, inspecting, or cleansing the site. LPN #370 stated without physician orders, there was no way to document when PEG tube care was provided, or whether it was provided. LPN #370 verified there should have been physician orders in place and documentation verifying PEG tube care was provided. LPN #370 stated the PEG tube site should be checked at least daily and the dressing should be changed at least daily.</p> <p>Review of the facility policy titled, Care and Treatment of Feeding Tubes, dated 01/01/25, revealed devices would be checked daily to assure the surrounding skin was intact. The policy also stated the facility would involve the physician or designated practitioner in evaluating and managing care to address complications and risk factors.</p> <p>Review of the facility policy titled, Clean Dressing Change, dated 06/01/24, revealed physician orders would specify the type of dressing and frequency of changes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to ensure central lines were cared for in accordance with professional standards of practice. This affected one (#323) of one resident reviewed for intravenous (IV) therapy. The facility census was 59.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #323 was admitted to the facility on [DATE]. Diagnoses included atherosclerosis of native arteries of extremities with gangrene, hypertension, end stage renal disease, type II diabetes mellitus, and hyperkalemia.</p> <p>Review of the admission Minimum Data Set (MDS) assessment, dated 04/09/25, revealed Resident #323 was cognitively intact. The resident had a central line.</p> <p>Review of the plan of care dated 04/18/25 revealed Resident #323 had potential for complications related to use of IV medications and/or IV fluids. Interventions included changing the dressing to the IV site as ordered and per facility policy, checking for signs and symptoms of infiltration at the site, and checking the IV site for signs and symptoms of infection.</p> <p>Review of a physician order dated 04/14/25 revealed Resident #323 had an order to flush subclavian IV antibiotic line with 10 milliliters (ml) of normal saline before and after medication administration every shift. There were no orders for monitoring the IV site or for dressing changes, including the type or frequency.</p> <p>Further review of Resident #323's medical record revealed no evidence the central line dressing had been changed.</p> <p>Observation on 04/30/25 at 9:15 A.M. of Resident #323's central line, with Registered Nurse (RN) #585, revealed the resident had a central line to his right chest. There was a transparent dressing, with a date that was illegible. Additionally, the dressing was rolled back and discolored. The resident's central line was completely uncovered and exposed. Concurrent interview with RN #585 verified Resident #323's central line was exposed and needed to be covered. RN #585 also verified the date on the dressing was unable to be read.</p> <p>Interview on 04/30/25 at 10:16 A.M. with Licensed Practical Nurse (LPN) #675 verified Resident #323 should have had a physician order for the central line dressing to be changed, adding staff would otherwise not know to change the dressing.</p> <p>Interview on 05/01/25 at 12:35 P.M. with RN #310 verified there were no orders to monitor Resident #323's central line site or for dressing changes. Further interview with RN #310 confirmed there was no evidence the facility had changed the central line dressing from admission (22 days earlier).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Central Vascular Access Device (CVAD) and Midline Catheter Dressing Changes, dated, revealed a sterile dressing would be applied and maintained on all midline catheters and CVADs (peripherally inserted central catheters, and accessed implanted ports), to secure the vascular access device, minimize site complications, and to detect and prevent other complications associated with infusion therapy. The policy further stated sterile transparent, semi-permeable membrane dressings were the preferred covering for CVAD and midline insertion sites due to allowed visualization of the insertion site. The policy stated dressings should be changed every five to seven days, when the site was rotated, if the integrity of the dressing was compromised, and/or upon suspected contamination. The CVAD and midline catheter skin sites and surrounding area should be assessed for redness, tenderness, swelling, and drainage upon admission, at least daily, and with dressing changes. The policy further stated documentation in the medical record would include the date and time of dressing changes, the type of dressing used, condition of the site, and the nurse's signature.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528</p> <p>Based on medical record review, resident interview, staff interview and review of facility policy, the facility failed to ensure resident pain was effectively managed. This affected one (#269) of one resident reviewed for pain management. The facility census was 59.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #269 revealed an admitted [DATE]. Diagnoses included fracture of the left lower leg, chronic pain, and anxiety.</p> <p>Review of the admission Minimum Data Set (MDS), dated [DATE], revealed Resident #269 was cognitively intact.</p> <p>Review of physician orders dated 04/25/25 revealed Resident #269 had orders for Tylenol 325 milligrams (mg) by mouth every four hours as needed for pain and oxycodone-acetaminophen 5-325 mg, give one tablet by mouth every six hours as needed for pain.</p> <p>Review of the Medication Administration Record (MAR) for April 2025 , dated 04/2025 revealed on 04/26/25 at 3:00 A.M., Licensed Practical Nurse (LPN) #360 administered Tylenol 650 mg to Resident #269 for a pain level of two. Further review of the MAR revealed the first dose of oxycodone-acetaminophen was not administered until 04/26/25 at 4:52 P.M. for a pain level of three.</p> <p>Interview on 04/28/25 at 10:40 A.M. with Resident #269 revealed she was only given Tylenol for pain when she was first admitted to the facility due to oxycodone-acetaminophen being unavailable. On a scale of one to 10, with 10 being the worst, Resident #269 stated her pain was a ten during the time the oxycodone acetaminophen was unavailable. Resident #269 stated the Tylenol brought her pain level down to around an eight; however, it did not last long before she was in severe pain, causing her to vomit.</p> <p>A telephone interview on 04/30/25 at 1:58 P.M. with LPN #490 revealed she was the nurse who entered Resident #269's admission medication orders. LPN #490 stated the facility's corporate office could not get a resident identification number for the resident so the medications could not be filled through the pharmacy. LPN #490 communicated with administration through a group chat letting the Administrator know the issues with the admission and medications. During this time, LPN #490 stated Resident #269 was in pain, quoting Resident #269 stated it hurts really bad, around a three. LPN #490 stated she told Resident #269 that she would pull the oxycodone-acetaminophen from the control box when the pharmacy verified it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview on 04/30/25 at 2:16 P.M. with LPN #360 revealed she was the night shift nurse for Resident #269 on 04/25/25 through 04/26/25. LPN #360 stated LPN #490 contacted the Director of Nursing (DON) and the Administrator regarding Resident #269's medication being unavailable. LPN #360 stated the pharmacy had denied the authorization to pull oxycodone-acetaminophen because they could not verify the resident number. LPN #360 stated the facility was finally able to get Resident #269 in the computer system at 2:00 A.M. on 04/26/25. LPN #360 verified that when Resident #269 requested pain medication on 04/26/25 at 3:00 A.M., she could have pulled the oxycodone-acetaminophen from the control box but did not because the pharmacy said they would be sending it in the delivery tote. LPN #360 confirmed oxycodone-acetaminophen was available for administration on 04/26/25 at 3:00 A.M. when the resident requested it and further verified she inaccurately documented in Resident #269's TAR that the resident's pain level was a two out of 10, but the resident actually reported a pain level of six out of 10.</p> <p>Review of the facility policy titled, Pain Management, dated 08/22/22, revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, and the resident's preferences.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>31638</p> <p>Based on resident interview, staff interview, review of the Facility Assessment (FA) and review of staffing reports, the facility failed to have sufficient staff to meet resident needs as identified in the FA. This had the potential to affect all 59 residents of the facility. The facility census was 59.</p> <p>Findings include:</p> <p>Interview with Resident #30 on 04/28/25 at 9:34 A.M. revealed the facility was extremely short staffed and her call light went unanswered on multiple occasions, which resulted in her urinating on herself in bed. Resident #30 revealed call lights were often unanswered within 30 minutes on second and third shifts.</p> <p>Interview with Resident #35 on 04/28/25 at 10:04 A.M. revealed Certified Nursing Assistants (CNAs) took a long time to answer call lights. Resident #35 stated staff instruct her to stay in bed until assistance arrived, but no one comes.</p> <p>Interview with Resident #269 on 04/28/25 at 10:36 A.M. revealed care was not provided timely and she had taken herself to the bathroom, even though she was directed to wait for staff assistance.</p> <p>Interview with Resident #18 on 04/28/25 at 10:43 A.M. revealed she had frequently wait for over 30 minutes for staff assistance after pressing her call light.</p> <p>Interview with Resident #28 on 04/28/25 at 3:24 P.M. revealed there were not enough CNAs, resulting in her incontinence brief not being changed timely.</p> <p>Interview with Licensed Practical Nurse (LPN) #913 on 04/30/25 at 4:40 P.M. verified the facility was short on staff, especially on second and third shift. While there were a sufficient number of nurses to complete their tasks, LPN #913 stated the CNAs could not handle the workload and respond to call lights timely to assist residents.</p> <p>Review of the FA, dated 07/29/24, revealed the facility identified second shift required six CNAs and the night shift required four CNAs for the entire shift to meet resident needs.</p> <p>Review of the Staffing Tool, dated 03/29/25, revealed the facility census was 66.</p> <p>Review of the facility staff clock in and out reports for 03/29/25 revealed on second shift (2:00 P.M. to 10:00 P.M.) four CNAs (#315, #475, #740, #820) worked the full shift. One CNA (#840) worked from 2:00 P.M. to 5:45 P.M. Two CNAs (#515 and #525) worked from 2:00 P.M. to 6:45 P.M. This revealed seven CNAs worked from 2:00 P.M. to 5:45 P.M., six CNA's from 2:00 P.M. to 6:45 P.M. and four CNAs cared for 66 residents from 6:45 P.M. to 10:00 P.M., resulting in only four CNAs from 6:45 P.M. until 10:00 P.M. when the FA identified six were needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Further review of the facility clock in and out reports for 03/29/25 revealed on third shift (10:00 P.M. to 6:00 A.M. on 03/30/25), two CNAs (#685 and #655) worked the full shift. CNA #440 worked from 1:45 A.M. to 6:45 A.M. One CNA (#315) worked from 10:00 P.M. to 2:15 A.M. and Medication Technician (MT) #540 worked from 10:00 P.M. to 2:45 A.M. This revealed that after 2:45 A.M., there were only three CNAs working when the FA identified four CNAs were needed for the entire shift.</p> <p>Interview on 05/01/25 at 9:15 A.M. with the Administrator, with concurrent review of the staff clock in and out reports, verified the facility had insufficient CNA staffing on 03/29/25 for both the second and third shift, based on the CNA staffing need identified in the facility in the FA.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164408.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on medical record review, review of pharmacy recommendations, staff interview and review of facility policy, the facility failed to ensure pharmacy recommendations were reviewed by the physician timely. This affected one (#3) of five residents reviewed for unnecessary medications. The facility census was 59.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included asthma, type II diabetes mellitus, schizoaffective disorder, depression, anxiety disorder, schizophrenia, and insomnia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/30/25, revealed Resident #3 was cognitively intact. The resident received antipsychotic and antidepressant medication.</p> <p>Review of Resident #3's physician orders revealed an order dated 01/30/24 for Famotidine (acid reducer) 40 milligram (mg) oral tablet, give one tablet by mouth at bedtime for ulcer. The resident also had an order dated 01/13/25 through 04/05/25 for Hydroxyzine (antihistamine) oral tablet 25 mg every eight hours as needed for anxiety.</p> <p>Review of the pharmacy recommendation, dated 03/23/25, revealed the pharmacist recommended to decrease Resident #3's Famotidine from 40 mg to 20 mg to ensure the lowest effective dose. The recommendation was not reviewed and signed by the physician until 04/26/24, which was 34 days after the recommendation was made.</p> <p>Review of the pharmacy recommendation, dated 02/28/25, revealed the pharmacist reported long-term care facility regulations stated all as-needed psychoactive medications must be limited to 14 days in duration. The recommendation further stated the provider must then reassess the resident to continue the as-needed order and must document clinical rationale for extended use and duration of treatment if the medication was to be continued. The recommendation was not reviewed and signed by the physician until 03/31/25, which was 31 days after the recommendation was made. At that time, the physician discontinued the medication.</p> <p>Interview on 05/01/25 at 3:18 P.M. with Licensed Practical Nurse (LPN) #710 verified the facility's policy was for the physician to review recommendations within 30 days.</p> <p>Review of the facility policy titled, Consulting Pharmacist Monthly Drug Review, dated 2016, revealed the consultant pharmacist would conduct monthly medication regime reviews, which would be reviewed by the medical provider within 30 days.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528</p> <p>Based on observation, medical record review, staff interview and review of the facility policy, the facility failed to properly store medications in a safe manner. This affected one (#21) of one resident reviewed for for medication storage. The facility census was 59.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included neuromuscular dysfunction of the bladder, benign prostatic hyperplasia, and unspecified pain.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated, revealed Resident #21 was cognitively intact.</p> <p>Review of the physician orders revealed an order dated for Xtampza ER (extended release oxycodone) 12 hour 18 milligram (mg), give one capsule by mouth two times a day for pain. Further review revealed no physician order for Resident #21 to self-administer medications or for medications to be left at the bedside.</p> <p>Observation on 05/01/25 at 7:47 A.M. revealed Resident #21 sitting in his wheelchair, reclined back with his eyes closed. Further observation revealed a medication cup with one unknown pill in it on Resident #21's bedside table. Concurrent interview with Resident #21 revealed the medication was given to him by the night shift nurse, and he had fallen asleep and forgot to take it.</p> <p>Interview on 05/01/25 at 7:48 A.M. with Licensed Practical Nurse (LPN) #675 confirmed the unattended medication on Resident #21's bedside table. LPN #675 stated the medication had been left by the night shift nurse and verified medications were not to be left unattended with Resident #21.</p> <p>A telephone interview on 05/01/25 at 12:16 P.M. with LPN #490 verified she left the medication, Xtampza, unattended on Resident #21's bedside table. Furthermore, LPN #490 confirmed Resident #21 did not have orders to leave medications at the bedside.</p> <p>Review of the facility policy titled, Medication Administration, dated 08/22/22, revealed to maintain compliance with medication administration, the nurse should observe the resident's consumption of medication.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44454</p> <p>Based on observation, staff interview and review of the facility policy, the facility failed to maintain a clean and sanitary kitchen and further failed to ensure food items were not stored directly on the floor. This had the potential to affect all 59 residents who received meals from the facility kitchen. The facility census was 59.</p> <p>Findings include:</p> <p>Observations on 04/28/25, beginning at approximately 8:15 A.M., revealed the following:</p> <p>The dry storage area, located in the main kitchen, revealed there were three crates of onions stacked and stored directly on the floor.</p> <p>The wall behind the dishwashing machine had an unknown black substance, which went from mid-wall down to the floor.</p> <p>There was buildup and debris under a metal table located in the kitchen.</p> <p>There was buildup and debris located against a wall and behind a refrigerator in the kitchen.</p> <p>A concurrent interview with Dietary Manager #750 verified the above findings. DM #750 reported the black substance behind the dishwashing machine was mold.</p> <p>Review of the facility policy titled, Food Safety Requirements, dated 01/01/25, revealed food would be stored in accordance with professional standards for food service safety. Food items located in dry storage areas would be kept off of the floor.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165111.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Crystal Care Center of Ashland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on observation, staff interview, medical record review, review of the Centers for Disease Control and Prevention (CDC) guidance and review of facility policy, the facility failed to ensure receptacles for contaminated personal protective equipment (PPE) were appropriately placed to prevent the transmission of pathogens. This affected one (#320) reviewed for urinary tract infections and medication administration. The facility census was 59.</p> <p>Findings included:</p> <p>Review of Resident #320's medical record revealed an admitted [DATE]. Diagnoses included methicillin susceptible Staphylococcus aureus (MSSA - infection caused by staph bacteria) infection of the left hip joint, alcoholism, and hepatitis C.</p> <p>Review of Resident #320's care plan revealed she required isolation/quarantine due to MSSA of a wound. Interventions included isolation/quarantine precautions would be maintained by staff during acute infection period.</p> <p>Review of Resident #320's physician orders revealed an order dated 04/11/25 for Cefazolin (antibiotic) two milligrams (mg) per 100 milliliters (ml) over 30 minutes intravenously (IV) every eight hours for left hip wound dehiscence/MSSA infection. Further review revealed an order dated 04/14/25 for contact isolation (measures taken to prevent the spread of infections that can be transmitted through direct or indirect contact with a resident or their environment) related to MSSA of the wound.</p> <p>Observation of medication administration on 04/29/25 at 1:57 P.M. with Licensed Practical Nurse (LPN) #370, revealed Resident #320's room door had contact precaution signs posted. LPN #370 and the surveyor donned a gown, gloves, and mask to enter the room. The IV medication was administered. The surveyor and LPN #370 stepped out in the hall and doffed the PPE and found there was no place to dispose of the contaminated PPE. Further observation revealed LPN #370 was required to walk back through Resident #320's room and place the contaminated PPE into a 32 gallon container with a red bag, which was placed near the window on the opposite side of the room from the door.</p> <p>Interview with LPN #370 on 04/29/25 at 2:05 P.M. verified the bin for contaminated PPE was placed on the opposite side of the resident's room and further stated it was set up that way for convenience since the room was quite small and the receptacle failed to fit by the exit door.</p> <p>Interview on 04/30/25 at 3:10 PM with Infection Control Preventionist (ICP) #310 confirmed the bin for contaminated PPE was located across the room from the door to Resident #320's room and staff had to walk back through the room to dispose of contaminated PPE.</p> <p>Review of the CDC guidance for contact precautions, located at https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html, revealed proper discarding of PPE before exiting the patient room is done to contain pathogens.</p>		