STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365945	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Care Center of Mansfie	1159 Wyandotte Ave Mansfield, OH 44906

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on record review, observation, and staff interview, the facility failed to implement protective boots designed to maintain skin integrity per the plan of care for Resident #55. This affected one (Resident #55) of 19 residents reviewed for care plan implementation. The facility census was 61. Findings include: Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included heart failure, spinal stenosis, and dementia. Review of the quarterly Minimum Data Set assessment, dated 06/11/24, revealed Resident #55 was cognitively intact and required substantial to maximal assistance from staff for putting on and taking off footwear. Review of Resident #55's physician orders for August 2024 identified an active order dated 01/18/24 for prevalon boots on while in bed, every shift for redness to bilateral heels. Review of the plan of care dated 01/12/24 revealed Resident #55 was at risk for impaired skin integrity related to impaired circulation, impaired mobility, advanced age, eczema, psoriasis, and incontinence. Interventions included padding and protecting skin as needed and pressure reduction devices if ordered. Observations on 08/25/24 at 11:20 A.M., 08/26/24 at 1:34 P.M., and 08/27/24 at 9:59 A.M. revealed Resident #55 was lying in bed with her heels lying directly on the mattress. The boots were not in place and were lying on the floor near the foot and partially underneath of the resident's bed. During an interview on 08/27/24 at 10:28 A.M., State tested Nurse Aide (STNA) #353 reported they provided care for Resident #55 on a regular basis. STNA #353 verified Resident #55 did not have the boots in place while lying in bed. STNA #353 reported the resident never wore the boots while in bed during the day.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure assistive devices were used appropriately to ensure a safe transfer. This affected one (Resident #41) of four residents reviewed for accidents. The facility census was 61. Findings include: Review of the medical record for Resident #41 revealed an admitted [DATE]. Diagnoses included dementia, Parkinson's disease, and heart failure. Resident #41 had impaired cognition. Review of the care plan dated 09/28/23 for Activities of Daily Living (ADLs) revealed staff were to use a mechanical lift for transferring Resident #41. Observation of 08/28/24 at 4:22 P.M. revealed State tested Nurses Assistant (STNA) #346 was transferring Resident #41 to her wheelchair out in the hall. STNA #346 was observed using the standing Hoyer (mechanical lift) on her own. As STNA #346 was unhooking the Hoyer arm, it hit the hand sanitizer on the wall and the hand sanitizer fell hitting Resident #41 in her left arm. Interview on 08/28/24 at 4:25 P.M. with STNA #346 stated when using the standing Hoyer lift or the ceiling Hoyer lift, you only need one staff member to transfer residents. STNA #346 verified she transferred Resident #41 with the standing Hoyer lift by herself. Interview on 08/28/24 at 4:29 P.M. with the Director of Nursing (DON) verified when transferring a resident with a standing Hoyer, staff always need two staff members and when using the ceiling Hoyer lift, you can use one or two staff members. Review of the facility policy titled Sit to Stand/Hoyer Lift Usage Policy, dated 08/22/23 revealed operate the lift according to the manufacture's instructions, with one staff member operating the lift and another supporting the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to assess the resident for the risks of entrapment with the use of bed rails prior to installation or use. This affected one resident (#168) of seven residents identified with orders for bed rails. The facility census was 61. Findings include: Review of Resident #168's medical record revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis, cerebrovascular disease, a stroke, muscle weakness, and seizures. The medical record revealed no evidence of an assessment for bed rails. There was a signed consent form for bed rails dated 08/08/13. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #168 had intact cognition and required substantial to maximum assistance of staff with bed mobility, and was dependent on staff for toileting, hygiene and transfers. The assessment did not identify bed rails as a restraint. Review of the care plan dated 07/17/24 revealed Resident #168 was at a fall risk and had seizures. Interventions included a bilateral half size bed rail. Review of the physician orders dated August 2024 revealed an order for padded bilateral half size bed rails to the bed at all times. Observation on 08/26/24 at 9:17 A.M. revealed Resident #168 was lying in bed. Resident #168's bed had padded metal bed rails on both sides of the bed and both rails were in the raised position. Interview at this time with Resident #168 stated she was afraid of falling out of the bed and needed the bed rails. Interview on 08/29/24 at 2:30 P.M. with MDS Nurse #331 verified there was no assessment for the use of side/assist/bed rails for Resident #168. MDS Nurse #331 stated she just started auditing assessments for bed rails and did not get to Resident #168. Review of the facility policy titled Bedrails dated 02/25/20 revealed when a bed or side rail is issued, the facility will ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. Assessing the resident for risk of entrapment from bed rails prior to installation. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. Follow the manufactures' recommendations and specifications for installing and maintaining bed rails.