STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365232	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancrest of St Mary's	1035 Hager Street St Marys, OH 45885

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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 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 medical record review, resident interview, staff interview and review of facility policy, the facility failed to implement appropriate infection control practices during care of residents on isolation. This affected Resident #2. Additionally, the facility failed to ensure proper signage was posted for type of isolation and usage of personal protective equipment (PPE) for residents who were on isolation. This affected four Residents (#59, #4, #1, #44, and #23). Six residents were reviewed for isolation practices. The facility census was 45.Based on medical record review, resident and staff interview, and policy review, the facility failed to implement appropriate infection control practices during care of residents on isolation. This affected one (#02) out of six reviewed for infection control. Additionally, the facility failed to ensure proper signage was posted for the type of isolation and usage of personal protective equipment (PPE) for residents who were on isolation. This affected six (#02, #59, #04, #01, #44, and #23) of six residents reviewed for isolation practices. The facility census was 45. Findings Include: 1.Review of the medical record for Resident #02 revealed an admission date of 12/04/25. The resident was admitted with diagnosis of pneumonia, hypoxia and pressure induced deep tissue damage of back and sacral area. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The Medicare five days were currently in progress. Review of the Care Plan revised on 12/15/25 revealed altered respiratory status related to pneumonia in hospital, acute respiratory failure with hypoxia, and history of emphysema. Observation on 12/16/25 at 9:50 A.M. revealed Resident #02 did not have a sign for isolation precautions. Interview and observation on 12/16/25 at 9:58 A.M. with License Practical Nurse (LPN) #234 revealed the facility practice was to place a See Nurse Sign on the residents' door and a symbol to represent what type of isolation the resident was in for staff to know. The LPN #234 verified Resident #02 did not have a see nurse sign or a symbol on doorway. LPN #234 placed a sign and a carrot symbolizing contact isolation on Resident #02's doorway. Observation on 12/16/25 at 10:53 A.M. revealed Resident #02 was in the restroom. Certified Nurse Assistant (CNA) #205 entered Resident #02's room, entered the restroom, assisted Resident #2 off the toilet and into a wheelchair, wheeled Resident #02 out of the resident's room, down the hallway (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and into the dining room without a mask. CNA #205 was not wearing personal protective equipment (PPE) when providing care in Resident #02's room. Interview on 12/16/25 at 11:01 A.M. with CNA #205 verified no PPE was worn when assisting Resident #02 with care. Interview on 12/16/25 at 11:02 A.M. with LPN #234 verified Resident #02 was diagnosed with pneumonia on 12/15/25 and Resident #02 should have a daisy (symbolizing droplet isolation) instead of a carrot. Reviewed isolation symbols with LPN #234 and they were the following: a daisy was for droplet isolation, a carrot was for contact isolation and an elephant was for enhanced barrier precautions. LPN #234 verified Resident #02 should be wearing a mask when ambulated through the halls and in the dining room. 2. Review of the medical record for Resident #59 revealed an admission date of 12/12/25. The resident was admitted with cutaneous abscess of right lower limb and type two diabetes. Review of the MDS assessment dated [DATE] revealed Resident #59 had a Brief Interview Mental Status (BIMS) score of 14, indicating intact cognition. The Medicare five day were currently in progress. Review of the Care Plan dated 12/16/25 revealed Resident #59 was at risk for alterations in nutrition and hydration due to facility placement due to cutaneous abscess right knee, intravenous antibiotic therapy and diabetes. Observation on 12/16/25 at 9:51 A.M. revealed Resident #59 had no sign for isolation precautions. Interview on 12/16/25 at 9:58 A.M. with LPN #234 verified Resident #59 did not have a see nurse sign or a symbol for isolation on doorway. The LPN #234 placed a sign and a carrot symbol indicating contact isolation on Resident #59's doorway. Interview on 12/16/25 at 11:55 A.M. with LPN #234 verified Resident #59 should not be in contact isolation and should be in enhanced barrier precautions. LPN #234 changed the carrot symbol to an elephant indicating enhanced barrier precautions for cutaneous abscess right knee, intravenous antibiotic therapy and diabetes . 3. Review of the medical record for Resident #04 revealed an admission date of 10/06/25. Diagnoses included intertrochanteric fracture of the left femur, diabetes, transient cerebral ischemic attack, stage three kidney disease, and a diabetic foot ulcer to the left heel. Review of the MDS assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated pressure ulcer, falls, pain, and nutritional status. Review of the Care Plan revised on 12/15/25 revealed acute pain related to recent fracture of left femur, risk of alteration in nutrition and hydration due to facility placement due to left hip fracture, diabetic foot ulcer to the left heel, and risk for falls related to a recent fracture of the left femur. Observation on 12/16/25 at 9:50 A.M. revealed Resident #04 had no sign for isolation precautions. Interview on 12/16/25 at 11:33 A.M. with LPN #234 verified Resident #04 did not have a see nurse (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sign or a symbol for isolation on doorway. LPN #234 placed a sign and an elephant (enhanced barrier precautions) on Resident #04's doorway for diagnosis of diabetic foot ulcer to left heel. 4. Review of Resident #01's medical record revealed an admission date of 09/27/24. Diagnoses included type II diabetes, cellulitis, colostomy complications, peripheral venous insufficiency, lymphedema, chronic gout, and methicillin resistant staphylococcus (MRSA). Review of Resident #01's MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #01 was cognitively intact. Resident #01 required touching assistance or supervision with toilet use, dressing, and personal hygiene. Resident #01 required maximal assistance with bathing. Review of Resident #01's care plan revised 10/30/25 revealed supports and intervention for contact isolation for extended spectrum beta lactamases (ESBL) and MRSA chronic in bilateral lower extremity wounds, self-care deficit, high risk for falls, pain, risk for fluid volume deficit related to diuretic use, and risk for impaired skin integrity. Review of Resident #01's physician orders revealed an order dated 12/04/24 to maintain contact isolation precautions related to ESBL and MRSA. Observation on 12/15/25 at 9:08 A.M. of Resident #01's room found Resident #1 was out of the room. A cart with personal protective equipment (PPE) was observed inside the door along with two lidded receptacles one labeled soiled linens and one labeled trash. A carrot symbol was observed next to Resident #01's name on the name plate outside of the room along with a sign saying to see nurse before entering the room. The carrot symbolized Resident #01 was on contact isolation. There were no postings found indicating what type of PPE was required to be used when providing care to Resident #01. Interview on 12/15/25 at 9:47 A.M. with LPN #242 verified Resident #01 was on contact isolation for ESBL and MRSA in bilateral lower extremity wounds. Observation on 12/15/25 at 11:33 A.M. of Resident #01's PPE cart and posted signage found no postings indicating what PPE was required to be worn, donned or doffed. Coinciding interview with LPN #242 verified there were no postings for PPE use. Interview on 12/15/25 at 11:36 A.M. with Resident #01 revealed he had seeping edema on his legs and the nurses applied wraps for him when they were due. Resident #01 verified there were a PPE cart and trash cans in his room for isolation. Resident #1 reported he was not sure he was still on isolation because he thought the staff were not using the supplies in the cart anymore. Observation on 12/16/25 at 9:12 A.M. and 12/17/25 at 8:05 A.M. of Resident #01's room found there continued to be no signage indicating what PPE was to be worn when providing care to Resident #01 who was on contact isolation. 5. Review of Resident #44's medical record revealed an admission date of 12/03/24. Diagnoses included cervical fusion of spine, spinal stenosis, type II diabetes, protein calorie malnutrition, conjunctivitis, anxiety disorder, and pruritus (itchy skin). Review of Resident #44's MDS assessment dated [DATE] revealed a Brief Interview for Mental (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Status (BIMS) score of 15 indicating Resident #44 was cognitively intact. Resident #44 was dependent on staff for toilet use, personal hygiene, bed mobility, and transfer. Resident #44 required maximal assistance with bathing, dressing. Resident #44 displayed no behaviors during the review period. Review of Resident #44's care plan revised 10/30/25 revealed supports and interventions for contact isolation related to extended spectrum beta lactamases (ESBL) in the urine, self-care deficit, pain, risk for alteration in skin integrity, and risk for falls. Review of Resident #44's physician orders revealed an order dated 01/20/25 to maintain contact isolation related to ESBL. Observation on 12/15/25 at 9:43 A.M. Resident #44 was in bed in her room. Resident #44 had a PPE cart and trash cans inside her room with a sign posted on her door frame to see nurse before entering. Additionally, Resident #44 had a carrot symbol next to her name on the room name plate. The carrot symbol indicated Resident #44 was on contact isolation. There was no signage posted indicating what PPE was to be used when providing care to Resident #44. Coinciding interview with Resident #44 verified staff wore PPE when providing her care. Interview on 12/15/25 at 9:47 A.M. LPN #242 verified Resident #44 was on contact isolation for ESBL in her urine. Observation on 12/15/25 at 11:32 A.M. of Resident #44's room and PPE cart found there continued to be no signage posted for what type of PPE was to be used when providing care to Resident #44 who was on contact isolation. Coinciding interview with LPN #242 verified there were no postings for PPE use when providing care to Resident #44 who was on contact isolation. Further observation on 12/16/25 at 9:10 A.M. and 12/17/25 at 8:28 A.M. of Resident #44 ' s room found there continued to be no signage indicating what PPE was to be worn when providing care to Resident #44 who was on contact isolation. 6. Review of the medical record review revealed Resident #23 was admitted on [DATE]. Diagnoses included pneumonia due to methicillin resistant staphylococcus aureus, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, type two diabetes mellitus without complications, hypotension, chronic kidney disease stage four, and major depressive disorder. Review of the MDS assessment dated [DATE] revealed Resident #23 was cognitively intact. Observation on 12/15/25 at 12:50 P.M. revealed the outside of Resident #23 ' s door a magnetic notice to see nurse prior to entering and a picture of a carrot symbol on the name plate. Inside of the room was a PPE cart with no signage. Interview on 12/16/25 at 3:29 P.M. LPN #242 verified Resident #23 ' s room had no PPE instructions. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions revised September 2022, revealed transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. Droplet precautions requires a mask is placed on the resident during transport from his or her room. The resident is encouraged to follow respiratory hygiene/cough etiquette to minimize dispersal of droplets. Review of the facility policy titled Personal Protective Equipment revised October 2018, revealed training on the proper donning, use and disposal of PPE is provided upon orientation and at regular intervals.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to ensure residents had accurate comprehensive, person centered and individualized care plans that reflected the residents' current orders, diagnoses and treatment decisions. This affected two (#5, #23) of two residents reviewed for care planning. The facility census was 45.Based on medical record review, staff interview and policy review, the facility failed to ensure residents had accurate comprehensive, person centered and individualized care plans. This affected two (#5 and #23) of two residents reviewed for care planning. The facility census was 45. Findings include: 1. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included aphasia (inability to talk) following intracranial hemorrhage (brain bleed), cerebral infarction (stroke), Sjogren syndrome (autoimmune disease where the body attacks moisture producing glands such as tear glands), depression, dementia, quadriplegia (decreased or lack of ability to move legs and arms), seizures, bipolar disorder, and anxiety. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had impaired cognition, as evidenced by a Brief Interview for Mental Status (BIMS) score of nine. Further review of the MDS revealed diagnoses of dementia, anxiety, depression, and bipolar disorder. The resident was receiving an antipsychotic medication. Review of the physician orders for Resident #5 revealed an order dated 07/04/25 for Abilify (an antipsychotic medication) 10 milligrams (mg) by mouth one time daily. Review of Resident #5's comprehensive care plan dated 09/15/25 revealed there was no care plan problem, goal, or interventions addressing the diagnosis of bipolar disorder. Further review revealed there was no care planning related to the use of an antipsychotic medication, including monitoring for effectiveness or potential adverse side effects. Interview on 12/17/25 at 1:33 P.M. with the Director of Nursing (DON) and the MDS Nurse #224 verified Resident #5 was prescribed Abilify, verified Abilify was an antipsychotic medication, and verified the resident had a diagnosis of bipolar disorder. Further interview verified there was no specific, individualized care plan addressing the use of an antipsychotic medication or the diagnosis of bipolar disorder. The MDS Nurse #224 further stated the facility was monitoring for side effects of the antipsychotic medication and the resident's bipolar disorder; however, this monitoring was documented under other care-planned areas and was not reflected in a clearly identified, individualized care plan addressing bipolar disorder or antipsychotic medication use. Review of the policy titled Behavioral Health Services, dated February 2019, revealed the facility will provide and residents will receive behavioral health services as needed to meet mental and psychosocial well-being in accordance with the plan of care and staff training include implementing care plan interventions that are relevant to the resident's diagnosis. 2. Review of the medical record review revealed Resident #23 was admitted on [DATE]. Diagnoses included pneumonia due to methicillin resistant staphylococcus aureus, methicillin resistant (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staphylococcus aureus infection as the cause of diseases classified elsewhere, type two diabetes mellitus without complications, hypotension, chronic kidney disease stage four, and major depressive disorder. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of the physician orders dated 04/14/25 revealed an order for Resident #23's advance directive as DNRCC-arrest (Do Not Resuscitate Comfort Care Arrest). Review of the DNR Comfort Care documentation dated 04/14/25, revealed a signed advanced directive verifying Resident #23's advance directive was DNRCC-arrest. Review of the care plan dated 07/31/23 revealed Resident #23's plan of care was the resident was a full code. Interview on 12/17/25 at 2:01 P.M. with the DON verified Resident #23's care plan for advanced directives were not accurate. Review of the policy titled Interdisciplinary Team Care Planning, dated March 2022, verified comprehensive, person-centered care plans are based on the resident assessments and developed by an interdisciplinary team.