STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365254	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancrest Health Care Center	10357 Van Wert Decatur Road Van Wert, OH 45891

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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 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** 41528 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure resident care conferences were offered and provided routinely as required. This affected two (#6 and #7) of two residents reviewed for care conferences. The facility census was 70. Findings include: 1. Review of the medical record revealed Resident #6 was admitted on [DATE]. Diagnoses included hypertensive heart and chronic kidney disease with heart failure, chronic kidney disease stage, type two diabetes mellitus, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 was cognitively intact. Review of the care plan conference documentation revealed Resident #6's last date of documented care conferences was 05/14/21. Interview on 04/29/25 at 4:07 P.M. with Social Services #134 verified Resident #6 has not had a formal care conference in quite a while. Social Services #134 stated care conferences were an open invitation or upon request at the frequency requested of the resident or resident representative. Social Services #134 stated the facility does not schedule regular care conferences. 2. Review of the medical record revealed Resident #7 was admitted on [DATE]. Diagnoses included hypertensive heart and chronic kidney disease, schizophrenia, type two diabetes mellitus with diabetic polyneuropathy, peripheral vascular disease, primary osteoarthritis, and depression. Review of the Minimum Data Set (MDS) assessment, dated 02/16/25, revealed Resident #7 was cognitively intact. Review of the care plan conference documentation revealed Resident #7 did have not have any care conferences since admission. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/29/25 at 4:07 P.M. with Social Services #134 verified Resident #7 did not have any formal care conference. Social Services #134 stated care conferences were an open invitation or upon request at the frequency requested of the resident or resident representative. Social Services #134 stated the facility does not schedule regular care conferences. Review of the policy titled Comprehensive Person-Centered Care Plans dated March 2022 revealed the interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the quarterly MDS assessment. The resident is informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, record review, family and staff interview, and review of the policy, the facility failed to ensure residents who were dependent on staff with activities of daily living were offered and fed their meals. This affected one (#45) resident observed during meal service. The facility census was 70. Findings include: Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses adult failure to thrive and dementia. Resident #45 was admitted to hospice care on 12/30/24. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/22/25, revealed Resident #45 had impaired cognition and was dependent on staff for eating. Resident #45 had no significant unplanned weight loss. Review of the current physician order, dated 12/26/24, revealed Resident #45 received a diet of no added salt/no concentrated sweets, pureed texture and nectar thick liquids. Observation on 04/28/25 at 11:06 A.M. revealed Hospice Aide (HA) #274 giving report to Licensed Practical Nurse (LPN) #114 regarding Resident #45. Observation on 04/28/25 at 11:16 A.M. revealed noon meal trays were delivered to Resident #45's hall. Concurrent observation revealed Resident #45 alone in her room, lying in bed sleeping. Continuous observations on 04/28/25 at 11:23 A.M. revealed Certified Nursing Assistant (CNA) #133 passing meal trays on the hall. Interview on 04/28/25 at 11:44 A.M. with CNA #133 confirmed one meal tray remained on the cart. CNA #133 stated the tray was for Resident #45. CNA #133 stated she did not pass the tray for Resident #45 because the hospice aide was working with Resident #45. Observation on 04/28/25 at 12:07 P.M. revealed Resident #45's noon meal tray remained on the tray cart. Concurrent interview with CNA #133 revealed she had no plans to offer Resident #45's meal tray because HA #274 told CNA #133 that Resident #45 was not very responsive that morning. Interview on 04/28/25 at 12:08 P.M. with LPN #114 confirmed she received report from HA #274 regarding Resident #45 and confirmed HA #274 had completed providing care for Resident #45 at the time of the report (11:06 A.M.). LPN #114 further stated HA #274 asked LPN #114 to have the facility CNA arouse Resident #45 and attempt to feed her when the noon meal tray arrived. LPN #114 stated she advised CNA #133 of the request. Interview on 04/30/25 at 3:56 P.M. with Resident #45's daughter revealed Resident #45's daughter did not want Resident #45 awoken for meals. However, Resident #45's daughter stated she would like staff to offer each meal. Follow-up interview on 05/01/25 at 11:17 A.M. with CNA #133 revealed LPN #114 did not tell her to offer the meal tray to Resident #45 on 04/28/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Assistance with Meals, revised 03/2022, revealed facility staff will serve resident trays and will help residents who require assistance with eating.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, review of the activity calendar, record review, resident and staff interview, and policy review, the facility failed to offer a variety of activities to the residents which meet the resident's needs and preferences. This affected five (#18, #38, #43, #56, and #63) of five residents reviewed for activities. The facility identified 34 residents who regularly attended activities. The facility census was 70. Findings include: 1. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including congestive heart failure, sciatica right side, chronic kidney disease, and weakness. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had preferences that were very important to the resident which included having books, newspapers, and magazines to read, listen to music she likes, keep up with the news, do things with groups of people, do favorite activities, and participate in religious services or practices. The quarterly MDS assessment dated [DATE] revealed Resident #18 was cognitively intact. Review of the Activity Participation Quarterly assessment dated [DATE] revealed Resident #18 previously stated she never felt socially isolated and currently continues to never feel socially isolated. Activities will encourage time spent outside of room with others. Activities will monitor activity levels and make changes as needed. Review of the care plan dated 02/12/25 revealed Resident #18 was pleasant and cooperative. Alert and oriented times three. Resident #18 did not want to participate in activities. Resident #18 never feels socially isolated. Interventions included activities will monitor and encourage her current activity level. Activities will continue to encourage daily self-initiated activities and current therapy goals to return home. The Activity Participation Quarterly assessment dated [DATE] revealed Resident #18 previously stated she never felt socially isolated and currently continues to never feel socially isolated. Activities will encourage time spent outside of room with others. Activities will monitor activity levels and make changes as needed. Interview on 04/30/25 at 1:32 P.M. with Resident #18 revealed the resident did not go to any activities. Resident #18 stated she does like to go outside when it was nice. Resident #18 stated she likes music type activities. Resident #18 verified the facility did not offer any activities in the evening. Resident #18 verified they offer two activities a day according to the activity calendar. Resident stated she plays cards on her I-pad in her room and watches her television shows in the evening. 2. Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses including spinal stenosis lumbar region, wedge compression fracture, dementia, anxiety, depression, hallucinations, and delusional disorders. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was cognitively intact. Preferences which were very important to the resident included listening to music they like, keeping up with the news, doing things with groups of people, doing favorite activities, and going outside to get fresh air when the weather is good. Review of the care plan dated 04/09/25 revealed Resident #38 was pleasant and cooperative. Resident #38 did not want to participate in activities. Resident's goal was to return to Assisted Living. Interventions included activities will ensure the resident has a positive rehabilitation experience. Activities will encourage daily self-initiated activities. Activities will monitor and encourage her current activity level. Activities will continue to encourage daily self-initiated activities. Interview on 04/30/25 at 2:15 P.M. with Resident #38 revealed the resident came to rehab from the assisted living part of the facility. Resident #38 stated they had not received an activity calendar. Resident #38 stated that no one from activities comes into her room to tell her about what activities were going on. The family member in room at the time confirmed the resident had no calendar for activities. 3. Review of the medical record for Resident #43 revealed admitted [DATE] with diagnoses including osteoporosis without current pathological fracture and congestive heart failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 was cognitively intact. Preferences which were very important to the resident included having books, magazines, and newspapers to read, do things with groups of people, do favorite activities, and go outside to get fresh air when the weather is good. Observation on 04/28/25 at 10:17 A.M. of the activity calendar posted on the resident's bathroom door revealed only two activities scheduled for the day. One-on-one visits at 10:00 A.M. and Bingo at 2:00 P.M. There were only two activities scheduled on most weekdays with one of the activities being one-on-one visits at 10:00 A.M. and another activity at 2:00 P.M. One activity was scheduled for Saturdays and Sundays. Interview on 04/29/25 at 11:58 A.M. with Resident #43 revealed the resident stated they did not go to activities. Resident #43 denied any activities staff coming to her room for any activity. Resident #43 denied any activity staff asking her to go to an activity. 4. Review of the medical record for Resident #56 revealed an admitted [DATE] with diagnoses including fracture of lower end of right tibia, displaced fracture of lateral malleolus of right fibula, generalized anxiety disorder, foot drop right foot (11/26/24), and major depressive disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed preferences that were very important for Resident #65 included doing favorite activities. The quarterly MDS assessment dated [DATE] revealed Resident #65 was cognitively intact. Review of the care plan dated 03/31/25 revealed Resident #56 was alert and oriented times three. Resident #56 prefers to structure day independently. Resident #56 continues to refuse out of room activities. Interventions included activities will encourage more time out of room daily. Activities will continue to encourage any activity involvement too. Activities will continue to encourage self-initiated activities as well as some out-of-room activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Activity Participation Quarterly assessment dated [DATE] revealed Resident #45 never felt socially isolated. Activities will encourage the resident to participate in activities they were interested in. Activities will offer assistance to and from activities. Activities will monitor the residents' activity levels for social isolation. Interview on 04/28/25 at 10:59 A.M. with Resident #56 revealed the resident did not feel the facility has enough activities and activities that they were interested in. 5. Review of the medical record revealed Resident #63 was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia and congestive heart failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 was cognitively intact. Preferences that were very important to Resident #63 included going outside when the weather is good, and participating in religious services or practices. Review of the care plan dated 04/21/25 revealed Resident #63 was pleasant and cooperative. Resident #63 was alert and oriented times three. Her goal was to return home. Resident #63 stated he often feels socially isolated. Interventions included activities will begin one-on-one support three times weekly to offer extra support and sensory stimulation. Activities will encourage more time out of her room either around others in a social environment or at activities large or small group as appropriate for her. Activities will support her goals to return home. Review of the Activity Participation Note dated 04/21/25 revealed Resident #63 was admitted facility on 04/18/25 and activities will support her goals. Interview on 04/30/25 at 2:20 P.M. with Resident #63 revealed the resident stated that they have not received an activity calendar and no one from activities lets them know about activities or offered to go to an activity. Observation on 04/30/25 at 1:50 P.M. of the activities room revealed no residents in the room. The 2:00 P.M. activity scheduled for that day (04/30/25) revealed it was Can It In the activity room. At 1:54 P.M., activities staff were observed wheeling one resident into the activity room. At 2:08 P.M., two residents observed in the activity room doing the activity. Interview on 04/30/25 at 2:45 P.M. with Activities Director (AD #269) revealed they had been at facility for [AGE] years. AD #269 verified they only hold the two activities each day normally. AD #269 stated that since COVID, the activity staff has seen a lower number of residents attending activities. AD #269 stated the one-on-one visits were for the residents who state they were always or almost always feeling socially isolated. AD #269 verified they only have one activity on the weekends. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy titled Activity Programs, revised June 2018, revealed the activities program is provided to support the well-being of residents and to encourage both independence and community interaction. The activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Activities are scheduled seven days a week and residents are given the opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the program. Individual and group activities are provided that reflect the schedules, choices, and rights of the residents, are offered at hours convenient to the residents, including weekends, evenings, and holidays, and reflect the cultural and religious interests, hobbies, life experiences and personal preferences of the residents.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, record review, and resident and staff interview, the facility failed to ensure wound treatments were completed per physician order. This affected one (#13) of two residents reviewed for wounds. The facility census was 70. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including peripheral vascular disease and type II diabetes mellitus. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 04/01/25, revealed Resident #13 had intact cognition. Review of the physician order initiated 04/12/25 revealed Resident #13 received betadine to the right great toe three times daily. Review of the Treatment Administration Record (TAR) dated April 2025 revealed Resident #13's right great toe treatment was provided once daily between 04/12/25 and 04/28/25. Review of the Weekly Wound & Skin Assessment Documentation revealed Resident #13's wound was identified 04/12/25 and initially assessed on 04/15/25. Weekly skin assessments, with measurements and description, revealed the wound was decreasing in size and the skin was pink and wound edges were intact. Measurements completed 04/29/25 revealed the wound was 1.5 centimeters (cm) in length, 2.4 cm in width, and 0.1 cm in depth. Interview on 04/28/25 at 10:47 A.M. with Resident #13 stated he had a sore on his right toe and he was supposed to receive daily treatment with a cream, but not a bandage. Resident #13 stated he had not received care for his toe yet that morning. Interview on 04/29/25 at 1:10 P.M. with Registered Nurse (RN) #126 confirmed Resident #13's right great toe treatment order indicated it should be completed three times daily, but was only scheduled once daily. RN #126 stated the wound looked like dry skin, and was improving. Interview on 04/29/25 at 2:00 P.M. with RN #182, who completed weekly wound care assessments, stated Resident #13's wound was considered an abrasion. Concurrent observation of Resident #13's right great toe revealed pink granulation tissue surrounded by intact skin. RN #182 stated the wound was improving. Follow-up interview and observation on 05/01/25 at 12:44 P.M. with RN #182 of Resident #13's right great toe revealed the wound bed had dark red granulation, was blanchable, had good blood flow and the surrounding tissue was pink with a healthy appearance. RN #182 further confirmed Resident #13's treatments were not completed three times daily as ordered between 04/12/25 and 04/29/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516 Based on record review, observation, and resident and staff interview, the facility failed to ensure medications were not left at the bedside. This affected one resident (#50) of four residents reviewed for medication administration. The facility census was 70. Findings include: Record review for Resident #50 revealed admitted [DATE] with diagnoses including fracture of right fibula, osteoporosis of left foot and ankle, effusion of right ankle, anxiety, and major depression. There was no self-administration of medication assessment. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was cognitively intact. Observation on 04/29/25 at 7:24 A.M. revealed Resident #50's was lying in her bed watching television with a bedside tray at her side. There were several unidentified medications in a small plastic medication cup placed on Resident #50's bedside tray. When Resident #50 was asked about the pills, Resident #50 did not respond, but picked them up and spilled the pills on her bed and then started to take medication one at time. Interview on 04/29/24 at 7:47 A.M. with Resident #50 stated she saw a nurse place medications on bedside tray and walk away. Resident #50 stated she liked to take her time taking her pills sometimes because there was a big pill in there in the morning and she chokes. Interview on 04/29/24 at 7:47 A.M. with Registered Nurse (RN) #137 verified she left Resident #50's morning medication on Resident #50's bedside tray and verified she should not have done that. However, RN #137 stated she normally does set her medications on her bedside tray for her to take them when she wakes up.