STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365680	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancrest of Hicksville	601 Defiance Avenue Hicksville, OH 43526

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on record review and staff interview, the facility failed to ensure residents received appropriate interest dividends based on the balance of their resident trust accounts. This affected five (#1, #2, #10, #16, and #34) of five residents reviewed for resident trust accounts. The facility identified 37 (#1, #2, #4, #5, #6, #7, #8, #9, #10, #12, #16, #17, #19, #20, #22, #23, #24, #25, #26, #27, #28, #30, #31, #32, #34, #36, #37, #38, #40, #41, #42, #44, #45, #47, #50, #51, and #52) residents with a resident trust account. The facility census was 51.Findings include:1. Review of the monthly resident trust statement for Resident #1, dated 04/01/26 through 04/30/26, revealed an ending account balance of $0.36 with an interest payment on 04/30/26 of $0.11. 2. Review of the monthly resident trust statement for Resident #2, dated 04/01/26 through 04/30/26, revealed an ending account balance of $1,335.17 with an interest payment on 04/30/26 of $0.11. 3. Review of the monthly resident trust statement for Resident #10, dated 04/01/26 through 04/30/26, revealed an ending account balance of $1,567.22 with an interest payment on 04/30/26 of $0.11. 4. Review of the monthly resident trust statement for Resident #16, dated 04/01/26 through 04/30/26, revealed an ending account balance of $1,776.02 with an interest payment on 04/30/26 of $0.05. 5. Review of the monthly resident trust statement for Resident #34, dated 04/01/26 through 04/30/26, revealed an ending account balance of $1,162.39 with an interest payment on 04/30/26 of $0.11. Interview on 05/06/26 at 10:45 A.M. with Business Office Manager (BOM) #279 revealed she was in the position for a year and managed resident trust accounts. BOM #279 stated the bank sent a bulk interest payment monthly and BOM #279 was trained to allocate interest payments evenly between all residents in the Skilled Nursing Facility (SNF) and the Assisted Living Facility (ALF). BOM #279 stated she did not consider the individual account balances when applying interest to the account. A follow-up interview on 05/07/26 at 12:29 P.M. with BOM #279 revealed she could not provide a reason why some residents received interest payments of $0.05 and others received $0.11 when she previously stated the bulk interest payment received from the bank was split evenly among all residents.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview and review of the menu spreadsheet, the facility failed to ensure residents on a mechanical soft diet received appropriate protein portions. This affected seven (#4, #7, #23, #42, #44, #48, and #50) residents who received mechanical soft textured protein. Additionally, the facility failed to ensure residents on a pureed diet received all components of the meal. This affected three (#5, #10, and #52) residents who received a pureed meal. The facility census was 51.Findings include:Observation during meal service on 05/06/26 at 12:07 P.M. revealed [NAME] #212 plating mechanical soft and pureed meals. Concurrent interview with [NAME] #212 confirmed she used a two-ounce scoop to serve mechanical soft meatloaf and she provided two scoops, for a total of a four-ounce portion. Further interview confirmed residents on a pureed diet received meatloaf, lima beans, and mashed potatoes.Interview on 05/06/26 at 12:32 P.M. with Dietary Manager #280 and concurrent review of the menu spreadsheet confirmed residents on a mechanical soft diet should receive a five-and-one-third ounce portion of meatloaf. Further review and interview confirmed residents on a pureed diet should receive pureed bread.Interview on 05/06/26 at 12:35 P.M. with [NAME] #212 confirmed pureed bread was not prepared or served with the noon meal.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and staff interview, the facility failed to ensure common bathrooms, accessible to residents in the facility, had emergency call lights. This had the potential to affect 36 (#1, #2, #4, #6, #7, #8, #9, #12, #13, #16, #17, #19, #21, #22, #23, #24, #25, #26, #27, #28, #30, #31, #32, #34, #37, #38, #40, #41, #44, #45, #46, #47, #51, #52, #54, and #60) residents identified by the facility as independently ambulatory. The facility census was 51. Findings include: Observations on 05/04/26 at 9:30 A.M., 11:35 A.M., 2:15 P.M. and 4:45 P.M. revealed two public restrooms were kept unlocked when not in use, with the doors standing open. The two restrooms were located near the entrance lobby of the facility.Interview on 05/04/26 at 3:56 P.M. with Registered Nurse (RN) #272 confirmed the two public restrooms off the main lobby were unlocked and accessible at all times.Interview on 05/04/26 at 4:05 P.M. with Assistant Director of Nursing (ADON) #226 confirmed the two public restrooms off the main lobby were accessible to residents and had no call lights for residents to use in case of emergency.Observation on 05/05/26 at approximately 6:20 P.M. revealed the bathroom doors remained opened and unlocked.Observation on 05/06/26 at approximately 3:30 P.M. revealed the bathroom doors remained opened and unlocked.Observation on 05/07/26 at approximately 10:00 A.M. revealed the bathroom doors remained opened and unlocked.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, staff interview and review of facility policy, the facility failed to accurately provide, monitor, and document fluid intake for residents on a fluid restriction. This affected one (#4) of one resident reviewed for a fluid restriction. The facility identified three (#4, #17, and #60) residents on a fluid restriction. The facility census was 51.Findings include:Review of the medical record for Resident #4 revealed an admission date of 12/22/25 with diagnoses of congestive heart failure (CHF), hypo-osmolality and hyponatremia, and hypertension.Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/12/26, revealed Resident #4 had intact cognition, had a significant weight gain, was not on a physician-prescribed regimen, and was on a therapeutic diet.Review of the current care plan, initiated 12/23/25 and updated 05/07/26, revealed Resident #4 had the potential for/at risk for an alteration in cardiac output/arrhythmia (irregular heart rate/rhythm/cardiorespiratory distress) related to CHF, hypertension and nonrheumatic aortic insufficiency. Interventions included assessing for edema (dated 12/23/25) and fluid restriction as ordered. Further interview revealed interventions added on 05/07/26 included may refuse to be compliant with fluid restriction. Additional review revealed a care area initiated 05/07/26 indicating Resident #4 had acute kidney injury and was diagnosed with hyponatremia. Resident #4 was on a fluid restriction and at times had been known to be non-compliant. Education was provided on the importance of following a fluid restriction. Review of a current physician order dated 02/17/26 revealed Resident #4 was on an 1800 milliliter (ml) fluid restriction related to hypo-osmolality and hyponatremia.Review of the nurses' paper charting, kept at the nurses' station, dated 02/17/26 through 05/06/26, revealed Resident #4's daily fluid intake ranged from 1560 ml to 2000 ml. Further review of the charting revealed the total daily intake included fluids from meals and fluids provided by nursing staff.Review of the nurse aide charting of daily fluid intake dated 04/07/26 to 05/07/26 revealed Resident #4's fluid intake varied from 540 ml per day (04/08/26) to 1450 ml per day (05/05/26).Review of the undated kitchen's posted fluid restriction allocation for Resident #4 revealed he received 360 ml of fluid at each meal. Observation on 05/04/26 at 10:10 A.M. revealed Resident #4 in his room sitting in a recliner. Resident #4 had no beverages in front of him. Further observation revealed Registered Nurse (RN) #272 entered the room and asked Resident #4 if he would like some water and where his water pitcher was. RN #272 stated it was unusual Resident #4 did not have a pitcher and said, at times, residents on a fluid restriction did not have water pitchers, but she did not believe Resident #4 was on a fluid restriction.Observation on 05/04/26 at 12:02 P.M. revealed Resident #4 in the dining room for the noon meal. Resident #4 had a glass of clear liquid beverage and a glass of orange juice. The glasses were approximately the same size. Observation on 05/05/26 at 1:17 P.M. revealed Resident #4 was in his room drinking a bowl of soup. A water pitcher was observed on the resident's overbed table. Concurrent interview with Resident #4 revealed he was having soup and crackers for lunch. Resident #4 confirmed he had a water pitcher filled with water on his overbed table. Resident #4 stated he was on a fluid restriction but he did not know why and had no further information regarding the fluid restriction.Interview on 05/05/26 at 2:58 P.M. with Licensed Practical Nurse (LPN) #227 revealed she documented fluid intake for Resident #4 on paper attached to a clipboard. Continued interview revealed LPN #227 stated Resident #4 was allowed 360 ml per meal and, therefore, LPN #227 charted he received 360 ml per meal. LPN #227 stated Resident #4 did not usually consume all the fluids he was allowed.Observation on 05/05/26 at 5:09 P.M. revealed Resident #4 seated at a table in the dining room. Resident #4 had a large cup of clear liquid and a cup of orange juice. Concurrent interview with Resident #4 revealed he requested soup for dinner. Observation on 05/06/26 at 8:10 A.M. revealed Resident #4 was in the dining room with a glass of orange juice, an empty glass of prune juice, and a cup of coffee. Concurrent interview with Dietary Aide (DA) #207 confirmed the glass of orange juice and the empty glass of prune juice were the same size glass and provided the surveyor with a duplicate sized glass.Interview on 05/06/26 at 4:15 P.M. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Dietary Manager (DM) #280, and concurrent observation of the glass provided by DA #207, revealed the glass held 240 ml of fluid. DM #280 confirmed Resident #4 should receive one 240 ml glass and one 120 ml glass of fluid at each meal. DM #280 further confirmed the coffee cups held 240 ml, for a total of 720 ml of fluids provided to Resident #4 during the breakfast meal. Interview on 05/07/26 at 7:48 A.M. with the Director of Nursing (DON) revealed Resident #4 was on a fluid restriction due to a history of fluid overload requiring hospitalization when the resident resided in the facility's Assisted Living (AL), prior to his admission to the long-term care facility.Interview on 05/07/26 at 8:12 A.M. with Certified Nursing Assistant (CNA) #264 confirmed she documented the amount of fluids residents consumed at meals. Concurrent observation revealed Resident #4 consuming beverages in the dining room. Continued interview with CNA #264 revealed CNA #264 could not estimate the amount of fluids Resident #4 consumed. CNA #264 stated she would document 100 (percent) if residents consumed all the fluids during their meal. CNA #264 further stated she sometimes documented 720 because that was how she was trained. Interview on 05/07/26 at 8:17 A.M. with CNA #245, and concurrent observation of two glasses of fluid in front of Resident #4 revealed CNA #245 could not estimate the amount of fluids in the glasses. CNA #245 identified a cup in front of Resident #4 and stated the covered, spill-proof, single-handled cup held 240 ml. Interview on 05/07/26 at 8:20 A.M. with LPN #227 revealed she did not know the volume of the cup in front of Resident #4 and LPN #227 therefore went to the kitchen and returned with a new cup and the written description for the cup. Continued interview and review of the cup's description revealed the cup, when filled to a specific level, contained seven ounces (approximately 210 ml). LPN #227 confirmed Resident #4's cup was filled above the line and confirmed the cup's instructions provided no guidance for estimating the volume of the cup when filled above the designated level.A follow-up interview on 05/07/26 at 8:51 A.M. with the DON revealed Resident #4 was not compliant with the fluid restriction at times and staff provided education. The DON confirmed no progress notes were documented regarding noncompliance or the provision of staff education.Interview on 05/07/26 at 2:00 P.M. with Registered Dietitian (RD) #300 revealed he was present in the facility one day every other week. RD #300 stated he verbally checked with staff regarding Resident #4's compliance with the fluid restriction. RD #300 stated he was not aware Resident #4 drank coffee with breakfast in addition to two types of juice. RD #300 stated he could not recall talking with Resident #4 about his preferences regarding beverages at meals.Review of the undated policy Fluid Restriction Policy revealed fluid restrictions must be initiated only with a physician/provider order specifying the total daily fluid allowance and any related dietary instructions or monitoring requirements. Additionally, fluid intake shall be monitored and documented according to physician orders and facility policy. Intake and output records shall be completed when ordered or clinically indicated. Further, resident refusals or noncompliance with fluid restrictions shall be documented. The physician/provider and responsible party shall be notified as appropriate based on clinical significance. Also, dietary services shall provide meal plans and beverages consistent with physician/provider orders and communicate any concerns regarding compliance or hydration status to nursing. Additionally, residents on fluid restrictions shall have individualized care plan interventions addressing monitoring, education, risks, resident preferences and compliance strategies as appropriate. Finally, the facility shall monitor compliance with fluid restrictions practices through audits, documentation review, and staff education to support resident safety and regulatory compliance.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, staff interview and review of the user manual, the facility failed to ensure insulin pens were primed correctly prior to administration. This affected one (#33) of two residents reviewed for insulin administration. The facility identified six (#09, #33, #43, #46, #47, and #56) residents who received insulin. The facility census was 51.Findings include: Observation on 05/06/26 at 7:58 A.M. revealed Licensed Practical Nurse (LPN) #247 obtained an insulin Lispro injection pen for Resident #33 from the medication cart and dialed the pen to two units and activated the injector. LPN #247 then applied the needle to the pen and dialed the pen to two units and injected Resident #33 with the insulin. LPN #247 did not prime the insulin pen prior to administration to Resident #33. Concurrent interview with LPN #247 verified the incorrect manner of priming the insulin pen prior to administration to Resident #33.Review of the educational material titled, Lilly Disposable Insulin Delivery Device User Manual, revised 05/02/05, revealed to ensure a needle was completely attached to the pen before priming, setting (dialing) the dose, and injecting the insulin.