

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Vancrest-Upper Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 3232 North County Road 25a Troy, OH 45373	
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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, observation, and policy review, the facility failed to properly assess and obtain consultation for existing pressure ulcers in a timely manner to prevent the worsening of a pressure ulcer. This resulted in Actual Harm on 06/26/26 when Resident #112 was admitted to the facility with a stage II pressure ulcer which was not assessed by the facility or the wound physician and deteriorated to a stage three pressure ulcer with slough to the wound bed. The facility also failed to administer pressure ulcer treatment per the physician's order. This affected one (Resident #112) of two residents reviewed for pressure ulcers. The facility census was 114 residents. Findings include: Record review revealed Resident #112 was admitted on [DATE] with diagnoses including Alzheimer's disease, left humerus fracture, sacrum fracture and hypertension. Review of the care plan for Resident #112 revealed the resident was at risk for the development of skin breakdown related to decreased mobility and incontinence. Interventions included the following: weekly skin assessments per nurse, assess and record changes in skin status, report changes in skin to the physician, complete skin risk assessment quarterly, minimize pressure over bony prominences, provide/monitor effectiveness of pressure relieving or reduction device. Review of the pressure ulcer risk assessment (Braden scale) for Resident #112 dated 06/25/26 revealed the resident scored a 15 on a scale of zero to 23 which indicated the resident was at mild risk for the development of pressure ulcers. Review of the progress note dated 06/26/26, written by Licensed Practical Nurse (LPN) #406 documented Resident #112 returned from a hospital stay with a fluid filled blister to right buttock measuring two centimeters (cm) in length by one cm in width with orders to apply skin prep to the area once daily and refer the resident to be evaluated by a wound specialist at Wound Company (WC) #1. Review of the physician's orders for Resident #112 revealed an order dated 06/25/26 for skin prep to right buttock/sacral area every shift for wound care with a start date of 06/25/26 and a stop date of 07/09/26. Review of the Minimum Data Set (MDS) assessment for Resident #112 dated 06/29/26 revealed the resident was cognitively impaired, required staff assistance with activities of daily living (ADL), and did not have pressure ulcers. Review of the Treatment Administration Records (TARs) for Resident #112 dated June and July 2026 revealed the treatment order to the right buttock was signed off as completed. Review of the medical record for Resident #112 dated 06/26/26 to 07/08/25 revealed there were no documented assessments or measurements of the wound to the resident's right buttock. Review of the progress note dated 07/09/26 and written by LPN #406 revealed the wound to the resident's right buttock was open and measured 1.6 cm in length by 1.4 cm in width by 0.2 cm in depth with yellow slough and a small amount of serosanguineous drainage noted to the wound bed. The nurse obtained a physician's order for a low air-loss and a referral to WC#1. Review of the weekly skin assessment for Resident #112 dated 07/09/26 per LPN #406 revealed the wound to the resident's right buttock was classified as a stage III pressure ulcer (a full-thickness loss of (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epiboly (rolled wound edges) are often present. Slough and/or eschar may be visible). Review of the physician's orders for Resident #112 revealed an order dated 07/10/26 to cleanse the pressure ulcer to the right buttock with saline, gently pack with calcium alginate, and cover with bordered foam daily and as needed. Review of the wound assessment note for Resident #112 dated 07/13/26 per Certified Nurse Practitioner (CNP) #300 with WC #1 revealed the resident had a stage III pressure injury to the right buttock which measured 2 cm in length by 1.5 cm in width by 0.2 cm in depth with a small amount of serosanguinous drainage noted. Part of the wound bed contained pink granulation but there was a large amount of adherent slough. CNP #300 mechanically debrided (a procedure in which a healthcare provider uses a scalpel, scissors, or curette to precisely cut away dead, damaged, or infected tissue from a wound) the wound bed. Resident #112 tolerated the procedure well with a pain level of two on a scale of zero to 10 with 10 being the worst pain and had a moderate amount of bleeding following the debridement which was controlled with pressure. Following the debridement the wound measured 2 cm in length by 1.5 cm in width by 0.3 cm in depth. Review of the care plan for Resident #112 dated 07/13/26 revealed the resident had an actual pressure ulcer related to decreased mobility, fragile skin, impaired nutritional status and incontinence. Interventions included the following: measure and document condition of skin weekly, provide resident with incontinence are after each incontinence episode, provide and monitor effectiveness of pressure relieving device. Review of the physician's orders for Resident #112 revealed an order dated 07/14/26 to cleanse the wound to the right buttock with saline, apply Medihoney and cover with bordered foam every dayshift and as needed. During an interview on 07/15/26 at 2:35 P.M., LPN #406 stated she assessed Resident #112's skin upon the resident's readmission from a hospital stay on 06/26/26 and noted the resident had developed a blister to the right buttock which she acknowledged was a stage two pressure ulcer. LPN #406 verified she obtained an order for skin prep the pressure ulcer and for the resident to be referred to WC #1 for evaluation of the wound. LPN #406 confirmed the facility did not assess Resident #112's wound again until 07/09/26 and at that time the wound had deteriorated to a stage III pressure ulcer with slough tissue present in the wound bed. LPN #406 stated the order for Resident #112 to be evaluated by a wound specialist with WC #1 was not implemented timely and the resident was not seen by CNP #300 until 07/13/26 at which time the wound required incisional debridement. LPN #406 further confirmed pressure ulcers should be assessed and measured at least once weekly. Observation on 07/16/26 at 9:13 A.M. of wound care for Resident #112 per LPN #406 revealed the nurse removed a white bordered dressing dated 07/15/26 with minimal drainage. The area under the dressing was raised and bright red with a dime-sized reddened open area. LPN #406 completed the treatment and applied foam bordered gauze per the physician's order. During an interview on 07/16/26 at 9:23 A.M., LPN #406 verified Resident #112's wound care physician's order was for foam bordered gauze and not a white bordered dressing which staff had applied to the wound on 07/15/26. LPN #406 stated it appeared Resident #112 had experienced an adverse reaction to having the wrong dressing applied on 07/15/26. Review of the facility policy titled Pressure Ulcer Risk and Management dated 01/20/25 revealed measurements and treatment evaluations of pressure areas would be completed weekly during skin rounds.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, manufacturer instruction, and policy review, the facility failed to maintain the ice machine and distribute food in a sanitary manner. This had the potential to affect all of the residents in the facility with the exception of four facility-identified (Residents #10, #32, #37 #55) who did not receive food from the facility kitchen. The facility census was 114 residents. Findings include: 1. Review of the monthly ice machine cleaning log revealed the kitchen ice machine was cleaned on 06/05/26. Observation 07/14/26 at 10:02 A.M. with the Dietary Manager (DM) revealed the ice machine had a thin black layer along the lip of the ice chute. The DM wiped the lip of the ice chute with a damp cloth and a black substance came off the chute onto the cloth. Interview on 07/14/26 at 10:03 A.M. with the DM confirmed the ice chute was dirty and the maintenance department was responsible to clean the ice machine on a monthly basis. Review of the manufacturer's instruction for the ice machine undated revealed the ice machine should be cleaned and sanitized every six months and when dirty. 2. Observation on 7/14/26 at 11:02 A.M. of the food line revealed [NAME] #403 with gloved hands moved the dish holder cart to her right, retrieved a package of buns, took the package of buns to the tray line, reached into the bag of buns with her gloved hand, removed a bun and prepared a sandwich. While wearing the same gloves [NAME] #403 continued to serve the lunch trays, using a gloved hand to remove tacos from the tray. The DM then walked around the tray line, obtained a set of tongs and laid them on the serving line in front of the tacos. Interview on 07/14/26 at 11:08 A.M. with the DM confirmed [NAME] #403 had stepped from the tray line touched unclean items and had then returned to the serving line and touched food items without changing gloves. Record review of the facility policy titled Food Preparation and Service dated October 2022 revealed cross contamination can occur when disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, utensils, etcetera that are not adequately cleaned.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interview and policy review the facility failed to offer and administer the Coronavirus (COVID-19) vaccines to employees. This had the potential to affect all residents in the facility. The facility census was 114 residents. Findings include: Interview on 07/15/26 at 3:32 P.M. with Business Office/Human Resource Manager (BO/HRM) #402 confirmed there are no employee vaccinations in the employee files. BO/HRM #402 stated Infection Control Nurse (ICN) #408 would have any employee vaccine forms. Interview on 07/15/26 at 3:40 P.M. with ICN #408 verified there was no documentation of any employee being offered or given the COVID vaccines per the COVID policies. Review of the facility policy titled Coronavirus Disease (COVID-19) dated May 2023 revealed all staff would be educated and offered the COVID-19 vaccine. Staff would record the date of administration of the COVID-19 vaccine and keep it in the employee file.		

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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 medical record review, review of resident fund accounts, staff interview, and policy review, the facility failed to ensure residents' personal funds were deposited in an interest-bearing account. This affected four (Residents #11, #22, #40, and #77) of six residents reviewed for resident fund accounts. The facility census was 114 residents. Findings include: 1. Review of the medical record for Resident #11 revealed an admission date of 01/27/25 with diagnoses including chronic obstructive pulmonary disease (COPD), hypertension (HTN), and Alzheimer's disease. Review of the resident funds authorization form for Resident #11 dated 12/03/25 revealed the resident authorized the facility to manage the resident's funds. Review of the quarterly statement for Resident #11 dated 06/20/26 revealed an account balance of \$374.15. The statement did not include documentation of disbursement of interest to the resident's account. 2. Review of the medical record for Resident #22 revealed an admission date of 11/02/24 with diagnoses including congestive heart failure (CHF), HTN, and dysphagia. Review of the resident funds authorization form for Resident #22 dated 08/05/25 revealed the resident authorized the facility to manage the resident's funds. Review of the quarterly statement for Resident #22 dated 06/20/26 revealed an account balance of \$650.00. The statement did not include documentation of disbursement of interest to the resident's account. 3. Review of the medical record for Resident #40 revealed an admission date of 05/07/22 with medical diagnoses including COPD, HTN, and cerebral infarction. Review of the resident funds authorization form for Resident #40 dated 05/07/22 revealed the resident authorized the facility to manage the resident's funds. Review of the quarterly statement for Resident #40 dated 06/20/26 revealed an account balance of \$237.60. The statement did not include documentation of disbursement of interest to the resident's account. 4. Review of the medical record for Resident #277 revealed an admission date of 07/27/22 with medication diagnoses of HTN, heart failure, and anxiety. Review of the resident funds authorization form for Resident #77 dated 03/08/23 revealed the resident authorized the facility to manage the resident's funds. Review of the quarterly statement for Resident #77 dated 06/20/26 revealed an account balance of \$1995.62. The statement did not include documentation of disbursement of interest to the resident's account. Interview on 07/15/26 at 3:39 P.M. with Accounts Receivable (AR) #255 confirmed the accounts for Resident #11, #22, #40 and #77 had not been placed in interest bearing accounts. AR #225 stated none of the residents who had RFA have received interest in the money in their accounts. Review of the facility policy titled Management of Residents' Personal Funds revised March 2021 revealed the resident may have the facility hold, safeguard, and manage his or her personal funds. The policy stated should the facility manage the resident's funds, the facility acts as a fiduciary of the resident funds and holds, safeguards, manages and accounts for the personal funds of the resident.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on medical record review, observation, staff interview, and policy review, the failed to ensure medications were not left unattended with a resident. This affected one (Resident #21) of three residents observed for medication administration. The facility also failed to ensure the medication cart was locked while left unattended in the hallway. This had the potential to affect the 15 facility-identified independently mobile residents on Center Hall (Residents #7, #16, #20, #22, #40, #49, #63, #64, #69, #89, #90, #93, #105, #118, and #119.) The facility census was 114 residents. Findings include: 1. Review of the medical record for Resident #21 revealed an admission date of 04/26/18 with diagnoses including diabetes mellitus, schizoaffective disorder, Alzheimer's disease, and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #21 dated 04/25/26 revealed the resident had severe cognitive impairment and required staff assistance with activities of daily living (ADLs.) Observation on 07/13/26 at 11:42 A.M. revealed Resident #21 sitting in a chair in the common area on the memory care unit with a medication cup with several medications in her hand. Licensed Practical Nurse (LPN) #324 was across the room assisting another resident with medication administration. Interview on 07/13/26 at 11:44 A.M. with LPN #324 confirmed she had given Resident #21 her medications and went across the room to assist another resident with medication administration. LPN #324 verified she had not stayed with Resident #21 to observe the resident consuming her medications. Review of the facility policy titled Administering Medications revised April 2019 revealed during administration of medications, the personnel administering the medication will stay in residents' presence until all medications have been given. 2. Observation on 07/14/26 at 7:30 A.M. revealed LPN #337 left the medication cart unlocked and unattended while she administered medications to Resident #118. The medication cart was in the hallway across from Resident #118's room. Resident #7 was near the medication cart at the time it was left unattended and unlocked. Interview on 07/14/26 at 7:40 A.M. with LPN #337 confirmed she had left the medication cart unlocked and unattended while she administered medications to Resident #118. Review of the facility policy titled Medication Labeling and Storage revised February 2023 revealed the facility ensures all medications are locked when unattended. Review of the facility policy titled Administering Medications revised April 2019 revealed the medication cart is kept closed and locked when out of sight of the medication nurse or aide.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on medical record review, staff interview and policy review the facility failed to offer influenza and pneumococcal vaccinations to residents. This affected four (Residents #22, #34, #59, and #111) of five residents reviewed for vaccinations. The facility census was 114 residents. Findings include: 1. Review of the medical record for Resident #22 revealed an admission date of 11/02/24 with diagnoses including congestive heart failure, dysphagia, and ulcer of the esophagus. Review of the medical record for Resident #22 revealed there was no documentation of the influenza or pneumococcal vaccine being offered or administered to the resident. 2. Review of the medical record for Resident #34 revealed an admission date of 09/06/24 with diagnoses including venous insufficiency, type two diabetes mellitus, and rheumatoid arthritis. Review of the medical record for Resident #34 revealed there was no documentation of the influenza or pneumococcal vaccine being offered or administered to the resident. 3. Review of the medical record for Resident #59 revealed an admission date of 06/24/25 with diagnoses including rheumatoid arthritis, dementia, and chronic kidney disease. Review of the immunization consent form for Resident #59 dated 06/25/25 revealed the resident's family representative gave consent for the resident to have the influenza vaccine and the pneumococcal vaccine. Further review of the medical record revealed Resident #59 was not administered the pneumococcal vaccine. 4. Review of the medical record for Resident #111 revealed an admission date of 06/09/25 with diagnoses including type two diabetes mellitus, nontraumatic subdural hemorrhage, and chronic obstructive pulmonary disease. Review of the immunization consent form for Resident #11 dated 06/10/25 revealed there was no consent for the influenza vaccine or the pneumococcal vaccine. Review of the immunization report for Resident #111 dated 07/15/26 revealed the resident received the influenza vaccine on 01/19/26. Interview on 07/15/26 at 3:04 P.M. with Licensed Practical Nurse (LPN) Unit Manager #408 confirmed there was no documentation of Residents #22 and #34 being offered or administered the influenza or pneumococcal vaccines. LPN #408 verified Resident #59 had not received the pneumococcal vaccine despite consent for the vaccine obtained on 06/25/25. LPN #408 stated there was no follow up on Resident #111 regarding if the pneumococcal vaccine was to be administered or not. Review of the facility policy titled Influenza Vaccine dated March 2022 revealed all residents will be offered the influenza vaccine annually. If a resident received or refuses the vaccine it will be documented in the medical record. Review of the facility policy titled Pneumococcal Vaccine October 2023 revealed all residents will be offered the pneumococcal vaccine. If a resident received or refuses the vaccine it will be documented in the medical record.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, observation, staff interview, and policy review, the facility failed to notify the physician of resident refusal of treatment. This affected one (Resident #94) of five residents reviewed for positioning. The facility also failed to notify the physician of weight changes as per the physician's order. This affected one (Resident #22) of five residents reviewed for nutrition. The facility census was 114 residents. Findings include: 1. Review of the medical record for Resident #94 revealed an admission date of 07/22/14 with diagnoses including diabetes mellitus, paraplegia, and chronic obstructive pulmonary disease. Review of the care plan for Resident #94 revealed it did not include use of the left hand splint nor did it include refusal of the splint. Review of the physician's orders for Resident #94 revealed an order dated 10/23/25 for a left hand splint as tolerated during first shift and to monitor for signs of redness or discomfort. Review of the Minimum Data Set (MDS) assessment for Resident #94 dated 05/14/26 revealed the resident had moderate cognitive impairment and limited range of motion to both upper and lower extremities. Review of the splint documentation for Resident #94 for April, May, and June 2026 revealed the resident refused to wear the splint to his left hand daily. Observation on 07/13/26 at 2:31 P.M. revealed Resident #94 had contractures to bilateral hands and was not wearing a hand splint on the left hand. Observation on 07/14/26 at 2:21 P.M. revealed Resident #94 was lying in bed with no hand splint noted to left hand. Interviews on 07/15/26 at 7:57 A.M. with Certified Nursing Assistants (CNAs) #309 and #289 verified Resident #94 had refused to wear the left-hand splint for several months. Interview on 07/16/26 at 8:22 A.M. with Licensed Practical Nurse (LPN) #406 verified she was the Unit Manager for Resident #94's hall and was not aware the resident had refused the left-hand splint for several months. LPN #406 confirmed Resident #94's physician had not been notified of his refusal to wear the left-hand splint as ordered. Review of the facility policy titled Change in Resident's Condition or Status undated revealed the facility should the attending physician of changes in the resident's medical/mental condition and/or status. The nurse should notify the resident's attending physician or physician on call when there has been a refusal of treatment or medications two (2) or more consecutive times. 2. Review of the medical record for Resident #22 revealed an admission date of 11/02/24 with diagnoses including congestive heart failure, dysphagia, and ulcer of the esophagus. Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 06/06/26 revealed the resident and required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #22 revealed an order dated 06/26/25 to be weigh the resident daily and to notify the physician if resident had a weight gain greater than two pounds in one day or five pounds in one week. Review of the weight record for Resident #22 revealed that on 06/28/26 the resident weighed 168.8 pounds and on 06/29/26 the resident weighed 172.0 pounds. There was no documentation of physician notification of the weight gain on 06/29/26. Review of the weight record for Resident #22 revealed that on 07/11/26 the resident weighed 174.0 pounds and on 07/12/26 the resident weighed 178.0 pounds. There was no documentation of physician notification of the weight gain on 07/12/26. Interview on 07/16/26 at 9:06 A.M. with Licensed Practical Nurse (LPN) Unit Manager #406 confirmed Resident #22 had a 3.2 pound weight gain on 06/29/26 and the physician was not notified on 06/29/26 per the physician order dated 06/26/25. Interview also confirmed Resident #22 had a 4.2 pound weight gain on 07/12/26 and the physician was not notified on 07/12/26 per the physician order dated 06/26/25. Further interview confirmed the physician was notified on 07/14/26 of the 07/12/26 weight gain of 4.2 pounds at which time the physician ordered Lasix 40 milligrams (mg) daily.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on medical record review, staff interview, review of the Resident Assessment Instrument (RAI) manual, and policy review, the facility failed to submit completed Minimum Data Set (MDS) assessments timely. This affected two (Residents #2 and #3) residents of three residents reviewed for discharges. The facility census was 114 residents. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of 02/24/26 with diagnoses including anemia, hypertension, and atherosclerotic heart disease and a discharge date of 03/06/26. Review of the medical record for Resident #2 revealed it did not include a discharge Minimum Data Set (MDS) assessment. 2. Review of the medical record for Resident #3 revealed an admission date of 02/26/26 with diagnoses including diabetes mellitus, cirrhosis of liver, and hypertension and a discharge date of 03/21/26. Review of the medical record for Resident #3 revealed it did not include a discharge MDS assessment. Interview on 07/15/26 at 8:59 A.M. with the Director of Nursing (DON) confirmed the facility had not submitted discharge assessments for Resident #2 and #3 to the Centers for Medicare and Medicaid Services (CMS). Review of the facility policy titled, MDS Completion and Submission Timeframes revised October 2021 revealed the facility would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy stated timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual (RAI). Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated October 2025 revealed on page 2-38 through 2-39 that discharge assessments must be completed within 14 days of the resident's discharge from the facility and submitted within 14 days of the MDS completion date.		

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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. Based on medical record review, observations, staff interview, and policy review, the facility failed to develop comprehensive person-centered care plans. This affected two (Residents #40 and #94) of five residents reviewed for activities of daily living (ADLs). The facility census was 114 residents. Findings include: 1. Review of the medical record for Resident #40 revealed an admission date of 05/07/22 with diagnoses including chronic obstructive pulmonary disease (COPD), cerebral infarctions, hypertension, and chronic respiratory failure. Review of the Minimum Data Set (MDS) assessment for Resident #40 dated 04/17/26 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #40 revealed an order dated 06/27/26 for an indwelling foley catheter and an order dated 06/29/26 to cleanse left forearm skin tear with saline, apply double layer xeroform and cover with bordered gauze, to change every other day and as needed. Review of the care plan for Resident #40 revealed the care plan did reflect the use of an indwelling catheter nor did it reflect the presence of the resident's skin tear to the left forearm. Interview on 07/15/26 at 11:33 A.M. with the Director of Nursing (DON) confirmed the facility had not developed a comprehensive person-centered care plan to address Resident #40's indwelling catheter or skin tear. 2. Review of the medical record for Resident #94 revealed an admission date of 07/22/14 with diagnoses including diabetes mellitus, paraplegia, and chronic obstructive pulmonary disease. Review of the care plan for Resident #94 revealed it did not include use of the left hand splint nor did it include refusal of the splint. Review of the physician's orders for Resident #94 revealed an order dated 10/23/25 for a left hand splint as tolerated during first shift and to monitor for signs of redness or discomfort. Review of the MDS assessment for Resident #94 dated 05/14/26 revealed the resident had moderate cognitive impairment and limited range of motion to both upper and lower extremities. Review of the splint documentation for Resident #94 for April, May, and June 2026 revealed the resident refused to wear the splint to his left hand daily. Observation on 07/13/26 at 2:31 P.M. revealed Resident #94 had contractures to bilateral hands and was not wearing a hand splint on the left hand. Observation on 07/14/26 at 2:21 P.M. revealed Resident #94 was lying in bed with no hand splint noted to left hand. Interviews on 07/15/26 at 7:57 A.M. with Certified Nursing Assistants (CNAs) #309 and #289 verified Resident #94 had refused to wear the left-hand splint for several months. Interview on 07/16/26 at 8:00 A.M. with MDS Nurse #409 confirmed Resident #94's care plans did not have documentation to support Resident #94 had a left-hand splint for contracture and that the resident refused to wear left-hand splint. Review of the facility policy titled Care Plans Comprehensive Person-Centered undated revealed the facility would develop comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs for each resident.		

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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. Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure residents received showers and assistance with grooming. This affected one (Resident #94) of five residents reviewed for activities of daily living (ADLs). The facility census was 114 residents. Findings include: Review of the medical record for Resident #94 revealed an admission date of 07/22/14 with diagnoses including encephalopathy, diabetes mellitus, chronic obstructive pulmonary disease, and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #94 dated 05/14/26 revealed the resident had moderate cognitive impairment and required substantial/maximum staff assistance with eating and personal hygiene and was dependent upon staff for bathing, bed mobility, and toilet hygiene. Review of the shower/bathing documentation for Resident #94 revealed the resident had received a shower/bath every Monday and Thursday from 06/15/26 to 07/13/26 as scheduled. Observation on 07/13/26 at 2:47 P.M. revealed Resident #94 lying in bed sleeping and had an overgrowth of facial hair. Observation on 07/14/26 at 2:21 P.M. of Resident #94 revealed facial hair growth and that resident had not been shaved. Observation on 07/15/26 at 7:55 A.M. revealed Resident #94 was lying in bed watching television and had an overgrowth of facial hair. Interview on 07/15/26 at 7:56 AM. with Resident #94 verified the facility staff had not shaved his face in a while. Interviews on 07/15/26 at 7:57 A.M. with Certified Nursing Assistants (CNAs #309 and #289 confirmed Resident #94 had not been shaved in several days. CNA #309 stated Resident #94 did not refuse care and staff were to shave the resident on shower days. Review of the facility policy titled Activities of Daily Living dated September 2023 revealed the facility staff would provide grooming assistance for residents who were unable to carry out ADLs independently. This deficiency represents noncompliance investigated under Complaint Number 2960631.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on medical record review, staff interview, and policy review, the facility failed to ensure interventions for contracture management were implemented as needed. This affected one (Resident #94) of two residents reviewed for positioning. The facility census was 114 residents. Findings include: Review of the medical record for Resident #94 revealed an admission date of 07/22/14 with diagnoses including diabetes mellitus, paraplegia, and chronic obstructive pulmonary disease. Review of the care plan for Resident #94 revealed it did not include use of the left hand splint nor did it include refusal of the splint. Review of the physician's orders for Resident #94 revealed an order dated 10/23/25 for a left hand splint as tolerated during first shift and to monitor for signs of redness or discomfort. Review of the Minimum Data Set (MDS) assessment for Resident #94 dated 05/14/26 revealed the resident had moderate cognitive impairment and limited range of motion to both upper and lower extremities. Review of the splint documentation for Resident #94 for April, May, and June 2026 revealed the resident refused to wear the splint to his left hand daily. Observation on 07/13/26 at 2:31 P.M. revealed Resident #94 had contractures to bilateral hands and was not wearing a hand splint on the left hand. Observation on 07/14/26 at 2:21 P.M. revealed Resident #94 was lying in bed with no hand splint noted to left hand. Interviews on 07/15/26 at 7:57 A.M. with Certified Nursing Assistants (CNAs) #309 and #289 verified Resident #94 had refused to wear the left-hand splint for several months. Interview on 07/16/26 at 8:22 A.M. with Licensed Practical Nurse (LPN) #406 verified she was the Unit Manager for Resident #94's hall and was not aware the resident had refused the left-hand splint for several months. LPN #406 confirmed Resident #94's physician had not been notified of his refusal to wear the left-hand splint as ordered. LPN #406 confirmed the facility had not implemented any interventions to treat the resident's contracture. Review of the facility policy titled Change in Resident's Condition or Status undated revealed the facility should the attending physician of changes in the resident's medical/mental condition and/or status. The nurse should notify the resident's attending physician or physician on call when there has been a refusal of treatment or medications two (2) or more consecutive times.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on medical record review, staff interview, and policy review, the facility failed to provide ongoing dialysis assessments and communications for a dialysis resident. This affected one resident (Resident #8) of one resident who received dialysis. The facility census was 114 residents. Findings include: Review of medical record for Resident #8 revealed admission date of 5/30/25 with diagnoses including end stage renal disease, chronic osteomyelitis, and dependence on renal dialysis. Review of the care plan for Resident #8 initiated 01/10/24 revealed the resident received dialysis. Interventions included the facility staff would coordinate the resident's care with the dialysis center. Review of the Minimum Data Set (MDS) assessment for Resident #8 dated 4/11/26 revealed the resident had intact cognition, required set up assistance with activities of daily living (ADLs), and received dialysis. Review of the care plan for Resident #8 initiated 01/10/24 revealed the resident received dialysis. Interventions included the facility staff would coordinate the resident's care with the dialysis center. Interview on 07/15/26 at 11:11 A.M. with Licensed Practical Nurse (LPN) #326 verified there was no routine paperwork documenting communication to or from the dialysis center on Resident #8's scheduled dialysis days. LPN #326 shared the only times she recalled an exchange of communication were if there was a diet change, a lab order or pertinent lab results. Interview on 07/15/26 at 2:09 P.M. with the Director of Nursing (DON) confirmed in the past the facility had used a flowsheet that was used for communication between the facility and the dialysis center. The DON verified the flowsheet had not been used since January 2026 and she was unsure why it had been discontinued. Review of the facility policy titled Dialysis revealed there should be ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments and ongoing communication and collaboration with dialysis facility regarding dialysis and services as outlined in agreement between the facility and the dialysis facility.		

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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 medical record review, observation, staff interview, and policy review, the facility failed to ensure blood pressure medication was administered as ordered. This affected one resident (Resident #118) of three residents reviewed for medication administration. The facility census was 114 residents. Findings include: Review of the medical record for Resident #118 revealed an admission date of 04/02/26 with diagnoses including chronic obstructive pulmonary disease (COPD), nonrheumatic aortic stenosis, and Raynaud's Syndrome. Review of the Minimum Data Set (MDS) assessment for Resident #118 dated 04/08/26 revealed the resident was cognitively intact and required assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #118 revealed an order dated 04/17/26 for amlodipine besylate (blood pressure medication) 5 milligram (mg) one tablet daily and to hold the medication for systolic blood pressure less than 100. Review of the blood pressure record for Resident #118 dated 07/12/26, 07/13/26, and 07/14/26 revealed there were no blood pressures recorded. Review of the Medication Administration Record (MAR) for Resident #118 revealed the facility staff administered amlodipine besylate to the resident on 07/12/26, 07/13/26, and 07/14/26. Observation on 07/14/26 at 7:30 A.M. revealed Licensed Practical Nurse (LPN) #337 administered amlodipine besylate tablet to Resident #118 but did not obtain a blood pressure prior to administration. Interview on 07/14/26 at 7:40 A.M. with LPN #337 confirmed she had not taken Resident #118's blood pressure prior to administering amlodipine. Interview on 07/14/26 at 11:08 A.M. the Director of Nursing (DON) confirmed Resident #118's medical record did not have documentation to support the facility staff obtained Resident #118's blood pressure prior to amlodipine besylate administration on 07/12/26, 07/13/26, and 07/14/26. Review of the facility policy titled Administering Medications revised April 2019 medications are administered in a safe and timely manner, and as prescribed. The policy stated medications are to be administered in accordance with prescriber orders, including any required timeframe.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on medical record review, staff interview and policy review the facility failed to communicate and collaborate with hospice services. This affected one (Resident #9) of two residents reviewed for hospice and end of life care. The facility census was 114 residents. Findings include: Review of the medical record for Resident #9 revealed an admission date of 06/16/23 with diagnoses including senile degeneration of brain, chronic kidney disease, metabolic encephalopathy, and type two diabetes mellitus. Review of the physician's orders for Resident #9 revealed an order dated 04/16/26 for the resident to admit to hospice services for a diagnosis of senile degeneration of the brain. Review of the Minimum Data Set (MDS) assessment for Resident #9 dated 04/27/26 revealed the resident was cognitively intact, required assistance with activities of daily living (ADLs), and received hospice care. Review of the care plan for Resident #9 dated 04/17/26 revealed resident was admitted to hospice services for senile degeneration of the brain. Interventions included the following: call hospice services with any changes, assist with ADLS, provide comfort measures as needed, hospice aide to visit weekly and as needed hospice nurse to visit weekly and as needed. Review of the medical record for Resident #9 revealed it did not include a signed hospice contract between the facility and the hospice provider nor did it include documentation of hospice nurse and aide visits. Interview on 07/15/26 at 1:11 P.M. with Licensed Practical Nurse (LPN) Unit Manager #407 confirmed Resident #9 continued on hospice services. LPN #407 stated there was not a signed contract with hospice services for Resident #9 and there was no communication or documentation present in the facility of hospice visits or any documentation of communication between the facility and the hospice provider. Review of the facility policy titled Hospice Services dated July 2017 revealed the facility would obtain from hospice the plan of care for the hospice resident, the hospice election form, the physician certification and recertification of the terminal illness specific for the resident and hospice physician and attending physician orders specific to each resident.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on medical record review, observation, staff interview, and policy review, the facility failed to follow infection control procedures during medication administration. This affected one (Resident #118) of three residents observed for medication administration. The facility also failed to follow transmission-based precautions. This affected one (Resident #129) of five residents reviewed for transmission-based precautions. The facility census was 114 residents. Findings include: Review of the medical record for Resident #118 revealed an admission date of 04/02/26 with diagnoses including chronic obstructive pulmonary disease (COPD), non-rheumatic aortic stenosis, and Raynaud's Syndrome. Review of the Minimum Data Set (MDS) assessment for Resident #118 dated 04/08/26 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #118 revealed orders dated 04/02/26 for Wellbutrin 150 milligram (mg) one tablet by mouth daily, Buspar 10 mg one tablet by mouth two times per day, docusate sodium 100 mg one tablet by mouth two times per day, and famotidine 40 mg one tablet daily and an order dated 04/20/26 for ferrous sulfate 325mg one tablet by mouth two times per day. Observation on 07/14/26 at 7:30 A.M. of Licensed Practical Nurse (LPN) #337 preparing medications for Resident #118 revealed one of the resident's medications packets had been opened and Wellbutrin, Buspar, docusate, ferrous sulfate, and famotidine tablets were laying on the bottom of the medication cart drawer. LPN #337 used a gloved hand to pick the medications off the bottom of the medication cart, verified the medications against the description on the medication packet, placed the medications into a medication cup, and administered the medications to the resident. LPN #337 put cup of medications to the resident's mouth and poured all the medications into her mouth at one time. One pill missed Resident #118's mouth and LPN #337 used her bare hand to pick the pill off of Resident #118's chest and placed it into the resident's mouth. Interview on 07/14/26 at 7:40 A.M. with LPN #337 confirmed Resident #118's medication packet had been opened prior to administration, and the medications had fallen out and were on the bottom of the medication cart drawer. LPN #337 verified she picked up the Wellbutrin, Buspar, docusate, ferrous sulfate, and famotidine tablets from the bottom of the medication cart drawer and placed them into a medication cup and administered the medications to Resident #118. LPN #337 stated she used her bare hand to take the pill from Resident #118's chest and placed the pill into Resident #118's mouth. Interview on 07/14/26 at 9:35 A.M. with the Director of Nursing (DON) #400 staff were not to administer medications from an opened medication packet nor were staff to administer medications that were found loose on the bottom of the medication drawer. 2. Review of the physician's orders for Resident #129 revealed an order dated 07/13/26 for contact precautions for methicillin-resistant staphylococcus aureus (MRSA) in surgical wound/ (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/14/26 at 8:07 A.M. revealed there was a sign posted to the right of the door frame of resident #129's which indicated the resident was on contact precautions everyone must clean their hands before entering and leaving the room. Providers and staff must also put on gloves before room entry and discard gloves before room exit, put on gown before room entry and discard gown before room exit and do not wear the same gown and gloves for the care of more than one person. Certified Nursing Assistant (CNA)#288 assisted Resident #129 onto the side of the bed. CNA #288 readjusted Resident #129's gown, physically assisted him to the standing position and held onto Resident #129's gown as he walked with him onto the bathroom and was no longer able to be observed from the hall. CNA #288 then exited the bathroom and walked straight into the hallway. Interview on 07/14/26 at 8:17 A.M. with CNA #288 verified Resident #129 was in contact isolation and he did not wash his hands after removing his gloves and exiting the resident's room. Review of the facility policy titled Isolation, Categories of Transmission-Based Precautions dated September 2022 revealed staff and visitors should wear gloves when entering the room. Gloves are to be removed and hand hygiene performed before leaving the room.		