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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366084 | A. Building<br>B. Wing | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Vancrest Health Care Center of Eaton | 1600 Park Avenue<br>Eaton, OH 45320 |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interview, and review of the facility policy, the facility failed to store food in a sanitary manner. This had the potential to affect all residents receiving meals from the facility kitchen. The facility census was 69 residents. Findings include: Observation on 02/23/26 at 10:10 A.M. of the walk-in freezer revealed it contained the following: a bag of ham in a zip lock bag with an expiration date of 05/29/24, two loaves of rye bread without expiration dates, a bag of opened and undated French fries. Observation on 02/23/26 at 10:20 A.M. of the reach in refrigerator revealed it contained a box of waffles opened and undated and a bag ravioli that was opened, undated, and had an expiration date of 08/03/25. Interview on 02/23/26 at 10:25 A.M. with Facility [NAME] (FC) # 202 verified the items in the walk-in freezer and the reach-in refrigerator should have been dated upon opening and discarded when expired. Review of the facility policy titled Storage of Staples dated January 2022 revealed frozen foods should not be stored in a frozen state for more than six months, and all staples should be dated upon delivery indicating the date product was received in the facility. |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>Based on review of facility documents and staff interview, the facility failed to conduct a complete assessment of the facility's risk for tuberculosis (TB.) This had the potential to affect all of the residents residing in the facility. The facility census was 69 residents.Findings include: Review of the facility's TB risk assessment worksheet revealed it was undated and unsigned, and many portions of the form were not completed. The following areas were not addressed: indication of the risk level for TB (low, moderate, or ongoing transmission), number of beds in the facility, indication if there was a high incidence of immunocompromised patients or healthcare workers in the facility. Interview on 02/25/26 at 11:40 A.M. with Registered Nurse (RN) #257, the designated Infection Preventionist (IP) for the facility, the Administrator, and the Director of Nursing (DON) confirmed the facility was a low-risk setting and had no current or recent cases of TB. RN #257 stated when she assumed the IP role she did not complete the TB risk assessment form in its entirety. Review of the facility policy titled Tuberculosis Policy and Procedure undated, revealed the tuberculosis risk assessment form should be completed yearly and reviewed by the DON or designee, the Administrator, and the Medical Director. |

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| F 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to manage his or her financial affairs.<br><br>Based on record review and staff interview, the facility failed to equitably credit interest earned from the shared resident trust account to individual resident trust accounts. This affected four (Residents #8, #39, #46 and #51) of 42 residents who had accounts with the facility. The facility census was 69 residents.Findings include: Review of resident trust account statements for Residents #8, #39, #46 and #51 revealed interest was added to the accounts randomly and was not calculated based on the balance of funds in the accounts.<br><br>Interview on 02/26/26 at 3:07 P.M. with Social Services Director (SSD) #253 and Assisted Living Director (ALD) #227 confirmed the facility did not add interest to individual resident accounts based on the balance of funds in the account. Interest was awarded to accounts monthly by alphabetical lists. SSD #253 confirmed they broke up the accounts managed by the facility into fourths and rotated through each list quarterly applying interest. SSD #253 and ALD #227 confirmed there were no calculations made of account balances and interest was awarded based solely on the alphabetical lists. SSD #253 and ALD #227 confirmed interest was not awarded equitably.<br><br>Interview on 02/26/26 at 3:07 P.M. with the Administrator confirmed the facility had not allocated interest to the individual resident trust fund accounts in an equitable manner, and interest should be calculated based on the balance of the individual resident account. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure medications were secure. This affected one (Resident #40) and had the potential to affect three residents identified by the facility as being cognitively impaired and independently mobile. The facility census was 69 residents. Findings include:Review of the medical record of Resident #40 revealed an admission date of 01/06/26 with diagnoses including type two diabetes mellitus, spinal stenosis, anxiety disorder, and overactive bladder.<br><br>Observation on 02/23/26 at 3:20 P.M. revealed Registered Nurse (RN) #262 entered Resident #40's room with a medication cup with various medications and a small tub of vanilla pudding. RN #262 placed the items on the overbed table and walked out of the room, closing the door behind her. Resident #40 began to take the medications, using pudding. RN #262 then returned to the room with a glass of water.<br><br>Interview on 02/23/26 at 3:21 P.M. with RN #262 confirmed she had left the medications unattended on Resident #40's overbed table.<br><br>Review of the facility policy titled Storage of Medications undated revealed drugs should be stored in a safe, secure, and orderly manner.<br><br>This deficiency represents noncompliance investigated under Complaint Number 2668753. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to perform proper incontinence care. This affected one (Resident #69) of one resident reviewed for incontinence care. The facility census was 69 residents. Findings include:Review of the medical record for Resident #69 revealed an admission date of 12/15/25 with diagnoses including end stage renal disease, chronic combined congestive heart failure, and hemiplegia and hemiparesis following a stroke.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #69 dated 12/22/25 revealed the resident was cognitively impaired, was dependent on staff for toileting, and had an indwelling urinary catheter.<br><br>Observation on 02/26/26 at 10:20 A.M. of catheter care for Resident #69 per Certified Nursing Assistants (CNAs) #269 and #285 revealed the aides removed the incontinent brief and used a disposable wipe to cleanse the resident's peri area separating the labia and wiping from the front to back. CNA #269 then arranged the wipe to a different section before wiping again. Observation revealed the wipe had brown colored material present after cleansing the urethral area. CNA #269 disposed of the wipe and pulled a clean wipe from the package. CNAs #269 and #285 completed perineal care to the resident's anterior side, reapplied the same incontinent brief and exited the room.<br><br>Interview on 02/26/26 at 10:40 A.M. with CNAs #269 and #285 verified the disposable wipe used for peri care for Resident #69 had brown material visible on the wipe after the first stroke during perineal care. The CNAs confirmed they did not provide any further perineal care to ensure the resident's posterior area was clean and free of irritation.<br><br>Interview on 02/26/26 at 10:52 A.M. with Registered Nurse (RN) #257 verified the CNAs should have provided thorough and complete incontinent care to Resident #69.<br><br>Review of the facility policy titled Incontinent Care undated revealed resident's skin should be kept clean, dry and free of irritation and odor. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on medical record review, observation, staff interview, and resident interview, the facility failed to ensure only licensed staff administered oxygen to residents and that oxygen tubing was handled in a sanitary manner. This affected one (Resident #49) of 14 facility-identified residents receiving oxygen. The facility failed also failed to ensure oxygen tubing was dated. This affected two (Residents#13 and #22) of 14 facility-identified residents receiving oxygen. The facility census was 69 residents. Findings include: 1.Review of the medical record of Resident #49 revealed an admission date of 10/23/25 with diagnoses include acute and chronic respiratory failure, pulmonary fibrosis, and interstitial lung disease.<br><br>Review of the physician's orders for Resident #49 revealed an order dated 10/31/25 for continuous oxygen at three liters per minute via nasal cannula.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #49 dated 12/28/25 revealed the resident cognitively impaired and received oxygen.<br><br>Observation on 02/23/26 at 11:59 A.M. revealed Resident #49 was seated in his wheelchair in the dining room, at a table with three other males. Certified Nursing Assistant (CNA) #321 disconnected the nasal cannula tubing from the portable oxygen tank and tucked it behind Resident #49. CNA #321 removed the tank from the holder on the wheelchair and walked with it to an oxygen storage room and placed the tank in a holder. Resident #49's oxygen tubing had fallen to the floor. Approximately three minutes later, Licensed Practical Nurse (LPN) #243 brought a new tank to Resident #49 and attached the tubing from off the floor to the new tank.<br><br>Interview on 02/23/26 at 12:03 P.M. with LPN #243 confirmed she had attached the tubing which had been lying on the floor to the new tank for Resident #49.<br><br>Interview on 02/23/26 at 12:07 P.M. with CNA #321 confirmed she had removed Resident #49's oxygen.<br><br>2. Review of the medical record for Resident #22 revealed an admission date of 12/26/24 with diagnoses including malignant neoplasm of the right lung and congestive heart failure.<br><br>Review of the MDS for Resident #22 dated 01/01/26 revealed the resident was cognitively intact and had shortness of breath when lying flat.<br><br>Review of the physician's orders for Resident #22 dated February 2026 revealed and order for oxygen at two liters per minute at night.<br><br>Interview on 02/23/26 at 2:02 P.M. with Resident #22 confirmed she experienced shortness of breath at night and she used oxygen at two liters at bedtime.<br><br>Observation on 02/25/26 at 8:17 A.M. revealed the oxygen tubing for Resident #22 was undated.<br><br>Interview on 02/25/26 at 8:18 A.M. with LPN #286 confirmed Resident #22's oxygen tubing was not dated and confirmed it should have been dated upon application.<br><br>3. Review of the medical record for Resident #13 revealed an admission date of 07/10/25 with<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | diagnoses including end stage renal disease, diabetes, and atrial fibrillation.<br><br>Observation on 02/25/26 at 2:57 P.M of Resident #13 revealed the resident was receiving oxygen via oxygen concentrator, and the oxygen tubing was undated.<br><br>Interview on 02/25/26 at 2:57 P.M. with LPN #286 confirmed Resident #13's oxygen tubing was undated and confirmed oxygen tubing should have been dated upon application |

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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.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospice visit logs, facility staff interview, hospice staff interview, and review of hospice contracts, the facility failed to ensure hospice documentation was sufficient and available for review by facility staff to ensure assessments, treatments and care planning were provided per plan of care. Additionally, the facility failed to jointly collaborate with hospice to develop resident care plans. This affected two (Residents #23 and #58) of two residents reviewed for hospice services. The census was 69 residents.Findings include:

1.Review of the medical record for Resident #58 revealed an admission on [DATE] with diagnoses including non-Hodgkin's lymphoma and heart failure.

Review of the Minimum Data Set (MDS) assessment for Resident #58 dated 01/31/26 for the resident revealed the resident had impaired cognition, was dependent on staff for activities of daily living (ADLs), and received hospice services.

Review of the hospice plan of care for Resident #58 dated 12/13/25 revealed hospice staff visits included a nurse visit one to two times a week for nine weeks and as needed visits for symptom management, a hospice aide visit three times a week for nine weeks, and a chaplain visit one to two times for two months with as needed visits for spiritual support.

Review of the hospice agency binder at the facility nurses station revealed the binder contained dates of hospice aide visits for Resident #58 dated 04/22/25, 04/25/25, 04/29/25, 05/02/25, 05/06/25, 05/09/25, 05/13/25, 05/16/25, 05/20/25, 05/23/25, 05/27/25, 07/18/25, 08/15/25, 01/20/26, 02/20/26, and 02/24/26. The binder did not include documentation of the services provided by aide.

Interview on 02/26/26 at 1:40 P.M. with Registered Nurse (RN) #257 confirmed the facility did not have any charting for bathing or shampooing for Resident #58 as this was completed by the hospice aide. RN #257 verified the hospice binder gave dates when the hospice aide was present at the facility but did not include documentation of care provided.

Interview on 02/26/2026 at 2:20 P.M. with Director of Nursing (DON) verified the facility staff does not have access to the hospice medical record or visit notes from the hospice providers. DON stated if the facility needs any information related to the hospice care of Resident #58 they have to call the hospice agency.

Interview on 02/26/26 at 3:48 P.M. with Hospice Registered Nurse (RN) #400 verified she did not develop Resident #58's hospice care plan in collaboration with the facility staff and did not review the facility care plan to ensure services provided by the hospice agency were identified. RN #400 stated she has not provided documentation to the facility regarding visits, assessments or treatments completed on a routine basis for Resident #58.

2.Review of the medical record for Resident #23 revealed an admission date of 11/01/24 with diagnoses including dementia, atherosclerotic heart disease, and congestive heart failure (CHF).

Review of the physician's orders for Resident #23 revealed an order dated 11/01/24 to admit the resident to hospice.
(continued on next page)

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the hospice care plan dated for Resident #23 dated 01/28/26 revealed the resident was admitted to hospice on 12/13/24 with a primary diagnosis of CHF. Hospice staff visits included a nurse visit one to two times per week for nine weeks and as needed for symptom management, a hospice aide visit twice a week for nine weeks, a chaplain visit one to two times per month for two months and as needed for spiritual support, and a social worker visit one to two times per month for two months and as needed for emotional support.<br><br>Review of the hospice visitation binder for Resident #23 dated 05/16/25 to 02/26/26 revealed the following visits were recorded: 12 hospice aide visits, two nurse visits, one chaplain visit.<br><br>Interview on 02/26/26 at 9:00 A.M. with RN #254 confirmed the facility had a log of visits by hospice staff for Resident #23 but did not have documentation regarding the services provided.<br><br>Interview on 02/26/2026 9:39 A.M. with Hospice RN #400 confirmed hospice staff documented on their mobile devices and the facility did not have access to these notes. RN #400 confirmed the facility could call hospice if they needed information on Resident #23.<br><br>Review of the nursing home hospice care agreement dated 10/01/19 revealed the hospice and the facility would jointly develop and agree upon a care plan which was consistent with the hospice philosophy and was responsive to the needs of the residents. It was the responsibility of the hospice agency to provide the facility with sufficient information to ensure services were being provided per the care plan. |