STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366108	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancrest of New Carlisle	1885 N Dayton Lakeview Rd New Carlisle, OH 45344

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, staffing interview, and policy review, the facility failed to provide residents and/or resident representatives with written notification of a room change. This affected three (Residents #06, #56, and #75) of the three reviewed for room changes. The facility census was 73. Findings include: 1. Review of the medical record for Resident #75 revealed an admitted [DATE] with medical diagnoses of specified disorders of the brain, dementia, aneurysm of the ascending aorta without rupture, hydrocephalus, and diaphragmatic hernia. The medical record indicated Resident #75 discharged on [DATE]. Review of the medical record for Resident #75 revealed an admission Minimum Data Set (MDS) assessment dated [DATE], which indicated Resident #75 had severe cognitive impairment and required supervision to touching assistance with eating and ambulation up to 50 feet, moderate staff assistance with toilet hygiene, bed mobility, and transfers, and maximum staff assistance with bathing. Review of the medical record for Resident #75 revealed a Social Service progress note dated 04/17/24 at 3:15 P.M. which stated Social Services and Resident #75's daughter discussed a possible room change and that Resident #75 would have a roommate. The note also stated Resident #75's daughter was informed that Medicaid would not pay for a private room and the daughter stated she was not sure that Resident #75 would be okay with that. Further review of the medical record revealed a Social Service progress note dated 04/23/24 at 11:30 A.M. which stated attempted to reach Power of Attorney (POA) to discuss move to long term care and a voicemail message was left. Review of the medical record revealed a Social Service note dated 04/30/24 at 10:59 A.M. which stated daughter accepted the long-term care room change. Review of the medical record for Resident #75 revealed Resident #75 moved rooms on 05/02/24. Review of the medical record did not reveal any documentation to support the facility provided a written notice of room change on 05/02/24. 2. Review of the medical record for Resident #56 revealed an admitted [DATE] with medical diagnoses of fibromyalgia, osteoarthritis, irritable bowel syndrome, and depression. (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #56 revealed a quarterly MDS dated [DATE] which indicated Resident #56 was cognitively intact and required moderate staff assistance with eating, maximum staff assistance with bed mobility, and was dependent upon staff for toileting, bathing and transfers. Review of the medical record for Resident #56 revealed a Social Service progress note dated 03/07/24 at 10:55 A.M. which stated Resident #56 and his daughter were informed about the move to long term care today. The note stated they both understood and agreed, and that Resident #56 would be moved. Review of the medical record for Resident #56 revealed Resident #56 moved rooms on 03/07/24. Review of the medical record did not reveal any documentation to support the facility provided a written notice of the room change on 03/07/24. 3. Review of the medical record for Resident #06 revealed an admitted [DATE] with medical diagnoses of Alzheimer's disease, low back pain, heart failure, osteoarthritis, and peripheral vascular disease. Review of the medical record for Resident #06 revealed a quarterly MDS dated [DATE] which indicated Resident #06 had severe cognitive impairment and required maximum staff assistance for eating and was dependent upon staff for toileting, bathing, and transfers. Review of the medical record for Resident #06 revealed a communication note dated 04/08/24 at 2:03 P.M. which stated Resident #06 moved to a different room and the family was aware. Review of the medical record revealed Resident #06 moved rooms on 02/07/24. Review of the medical record for Resident #06 revealed no documentation to support the facility provided a written notice of the room change on 04/08/24. Interview on 06/03/24 at 11:26 A.M. with Social Service (SS) #235 confirmed the medical records for Resident #06, #56, and #75 did not contain documentation to support the facility provided the resident or resident representative with written notification of room change. SS #235 stated she verbally notified the residents or resident representatives of the room changes and documented in the progress notes. Review of the facility policy titled, Room change/Roommate Assignment, revised March 2021 stated changes in room or roommate assignment are made when the facility deems it necessary or when the resident requests the change. The policy stated prior to changing a room or roommate assignment, all parties involved in the change/assignment are given a reasonable advance written notice of such change. The policy stated residents have the right to refuse to move to another room in the facility if the purpose of the mode is to relocate the resident from a skilled nursing unit within the facility to one that is not a skilled nursing unit and that if a resident exercises his/her right to refuse a room change, this will not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits. This deficiency represents non-compliance investigated under Complaint Number OH00153799.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review and staff interview, the facility failed to provide accurate resident medical information when transferred to a hospital. This affected one (#75) resident out of the three residents reviewed for change of condition. The facility census was 73. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] with medical diagnoses of specified disorders of the brain, dementia, aneurysm of the ascending aorta without rupture, hydrocephalus, and diaphragmatic hernia. The medical record indicated Resident #75 discharged on [DATE]. Review of the medical record for Resident #75 revealed an admission Minimum Data Set (MDS) assessment dated [DATE], which indicated Resident #75 had severe cognitive impairment and required supervision to touching assistance with eating and ambulation up to 50 feet, moderate staff assistance with toilet hygiene, bed mobility, and transfers, and maximum staff assistance with bathing. Review of the medical record for Resident #75 revealed a hospital discharge summary dated 04/03/24, which indicated Resident #75 was treated for obstructive hydrocephalus status post ventriculoperitoneal (VP) shunt (a cerebral shunt that drains excess cerebrospinal fluid when there is an obstruction in the formal flow) placement. Review of the medical record for Resident #75 revealed it did not contain documentation to support the facility added a diagnosis related to recent VP shunt placement or developed a comprehensive care plan which indicated Resident #75 had a VP shunt. Review of the medical record for Resident #75 revealed a nurse progress note dated 05/09/24 at 1:34 P.M. which stated Resident #75 was sent to the emergency department (ED) for a fall and change in condition. The note indicated the nurse prepared paperwork for the medics. The medical record did not contain documentation to support the facility called the ED to provide them with a report on Resident #75's medical condition or medical diagnoses. Interview on 06/03/24 at 2:13 P.M. with the Director of Nursing (DON) stated when a resident is sent to the ED the nurse is to provide the medics with the resident's face sheet, advanced directives, physician orders, and most recent labs. The DON confirmed the medical record for Resident #75 did not contain documentation to support a recent VP shunt placement. The DON also confirmed the nurse did not call report to the ED on 05/09/24 to update the hospital of Resident #75's medical status or current medical diagnoses. This deficiency represents non-compliance investigated under Complaint Number OH00153799.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to develop a resident centered comprehensive care plan. This affected one (#75) resident out of five residents reviewed for comprehensive care plans. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] with medical diagnoses of specified disorders of the brain, dementia, aneurysm of the ascending aorta without rupture, hydrocephalus, and diaphragmatic hernia. The medical record indicated Resident #75 discharged on [DATE]. Review of the medical record for Resident #75 revealed an admission Minimum Data Set (MDS) assessment dated [DATE], which indicated Resident #75 had severe cognitive impairment and required supervision to touching assistance with eating and ambulation up to 50 feet, moderate staff assistance with toilet hygiene, bed mobility, and transfers, and maximum staff assistance with bathing. Review of the medical record for Resident #75 revealed a hospital discharge summary dated 04/03/24, which indicated Resident #75 was treated for obstructive hydrocephalus status post ventriculoperitoneal (VP) shunt (a cerebral shunt that drains excess cerebrospinal fluid when there is an obstruction in the formal flow) placement. Review of the medical record for Resident #75 revealed no documentation to support the facility developed a comprehensive person-centered care plan which indicated Resident #75 had a VP shunt. Interview on 06/03/24 at 2:43 P.M. with Registered Nurse (RN) #203 confirmed the medical record for Resident #75 did not contain documentation to support a diagnosis for VP shunt or a comprehensive care plan which indicated Resident #75 had a VP shunt. RN #203 confirmed the facility utilizes the RAI manual for policy and procedures related to comprehensive care plans. Review of the RAI manual dated October 2023 revealed the facility must develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment. Further review of the RAI manual revealed care plans are to reflect appropriate resident-specific approaches to care based on careful consideration of individual problems and causes. The deficiency is based on incidental findings discovered during the course of this complaint investigation.