STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366255	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancrest Health Care Ctr of Ho	600 Joe E Brown Road Holgate, OH 43527

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, and review of facility policy, the facility failed to ensure the snack/nourishment refrigerator for the 300 Hall and 400 Hall nurses' stations was maintained with properly dated and labeled food and beverage items to prevent the potential for foodborne illness. The facility identified thirty-one residents (#1, #4, #9, #14, #16, #17, #18, #19, #20, #23, #24, #26, #27, #28, #29, #30, #31, #32, #33, #36, #39, #40, #42, #44, #46, #48, #50, #55, #57, #59, and #67) who receive nourishments from the refrigerator. The facility census was 56.Findings include:Observation on 02/18/26 at 1:58 P.M. of the 300 Hall and 400 Hall nurses' station refrigeration unit revealed salami and pepperoni stored in unlabeled and undated plastic bags with a visible white film and and mold like substance observed. Further observation revealed outdated yogurt cups; expired fruit cups; expired pudding cups; Mexican food in a leftover container was uncovered and not dated; leftover containers not labeled with a resident name or date; one glass of orange juice was left open to the air with no lid, label, or date; and a bag of shredded cheese that was not labeled or dated and appeared melted inside the bag. An unlabeled and undated frozen dinner meal was stored in the refrigerator drawer. Interview on 02/18/26 at 1:58 P.M. with Social Worker (SW) #237 and the Administrator verified the above observations.Interview on 02/18/26 at 3:43 P.M. with Licensed Practical Nurse (LPN) #280 verified the refrigerator at the nurses' station was used for residents residing on the 300 and 400 hallways. LPN #280 stated there were currently no residents on those hallways who did not consume food orally. LPN #280 further verified all food items should be dated and labeled, including food items used during medication passes.Review of the undated facility policy titled, Food Brought in by Families/Visitors, revealed food requiring refrigeration shall be labeled with the resident's name, contents, and the date received, and stored in a designated refrigerator. The policy further stated unconsumed food would be disposed of according to manufacturer guidelines, expiration dates, food labels, or upon evidence of spoilage.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on resident interview, observation, medical record review, the review of dietary meal ticket, staff interview, and review of facility policy, the facility failed to honor residents' food preferences. This affected one (#49) of two residents reviewed for preferences. The facility census was 56. Findings include:Review of the medical record for Resident #49 revealed an admission date of 12/10/25. Diagnoses included fracture of superior rim of left pubis, subsequent encounter for fracture with routine healing, chronic atrial fibrillation, unspecified diastolic (congestive) heart failure, and chronic kidney disease.Review of the Minimum Data Set (MDS) assessment, dated 12/12/25, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Interview with Resident #49 on 02/17/26 at 8:30 A.M. revealed she did not like sausage and the facility kept serving her sausage. Concurrent observation of Resident #49's breakfast meal tray revealed she was served sausage with her breakfast. Resident #49 stated the facility was aware she disliked sausage. Observation of Resident #49's breakfast meal tray on 02/17/26 at 8:30 A.M. revealed the resident was served sausage and gravy over biscuits, half a bowl of cereal, a fried egg, juice, almond milk and hot water for tea. Further observation of Resident #49's dietary meal ticket revealed the resident disliked sausage.Interview with Certified Nursing Assistant (CNA) #272 on 02/17/26 at 8:44 A.M. verified Resident #49 received sausage and gravy for breakfast. Further interview with CNA #272, and concurrent review of Resident #49's dietary meal ticket, confirmed the meal ticket identified the resident did not like sausage. Observation on 02/17/26 at approximately 9:00 A.M. of Resident #49's breakfast meal tray, once the meal was complete, revealed the resident ate the cereal and fried egg; however, Resident #49 did not eat the sausage and gravy. Review of the facility policy titled, Resident Food Preferences, dated July 2017, revealed nursing staff would document the resident's food and eating preferences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interviews, and review of facility policy, the facility failed to ensure enteral tube feedings were correctly labeled and dated. This affected one (#20) of one resident reviewed for enteral tube feedings. The facility census was 56.Findings include:Review of the medical record for Resident #20 revealed he was admitted on [DATE]. His diagnoses included dysphagia (difficulty swallowing) following a stroke, right-sided paralysis, aphasia (difficulty speaking), intracerebral hemorrhage, seizures, neurogenic bladder, and protein-calorie malnutrition.Review of the admission Minimum Data Set (MDS) assessment, dated 11/11/25, revealed Resident #20 was cognitively intact and did not display any behaviors at the time of the assessment. Resident #20 received 51% or more of his nutrition from a feeding tube.Review of the physician orders for Resident #20 revealed an order dated 02/09/26 for a puree diet and an order dated 02/11/26 for Jevity 1.5 (nutritional formula) to be administered each night from 9:00 P.M. to 5:00 A.M. at 60 milliliters (mL) per hour with 100 mL water boluses prior to starting and after completing the Jevity 1.5 administration.Observation on 02/17/26 at 9:00 A.M. of Resident #20's enteral tube feeding hanging in his room revealed a tube feeding bag filled with 600 mL of a light brown fluid and a tube feeding bag filled with 1000 mL of a clear liquid hanging from a feeding pump pole. The tube feeding bags were not labeled nor dated.Interview on 02/17/26 at 4:35 P.M. with the Director of Nursing (DON) confirmed Resident #20's tube feeding bags were not labeled to indicate what was contained in the bag, nor dated, and should have been.Interview on 02/18/26 at 2:00 P.M. with Licensed Practical Nurse (LPN) #230 revealed when a tube feeding was administered, it should be labeled with the name of the formula, the date it was hung, and the time it was hung. Further interview revealed once a formula was hung, it must be used or discarded within 24 hours of opening.Review of an undated facility policy titled, Tube Feeding Administration and Hanging Guidelines, revealed enteral tube feedings would be labeled with the date and time they were hung and would be administered or discarded within 24 hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, medical record review, and review of the facility policy, the facility failed to obtain an order for oxygen therapy. This affected one (#64) of one resident reviewed for oxygen therapy. The facility identified nine residents (#25, #27, #41, #43, #47, #51, #53, #55, and #64) who received oxygen therapy. The facility census was 56.Findings include:Review of the medical record for Resident #64 revealed an admission date of 02/16/26 with admitting diagnoses of fall with displaced rib fractures of ribs seven through eleven.Review of the hospital Community Referral Form (CRF) dated 02/16/26 for Resident #64 revealed no orders for supplemental oxygen therapy.Review of the admission physician orders for Resident #64 revealed no orders for oxygen therapy.Observation on 02/17/26 at 11:00 A.M. of Resident #64 revealed the resident was resting in bed with oxygen in place and running at three l/m via nasal cannula (NC).Interview on 02/17/26 at 1:54 P.M. with Licensed Practical Nurse (LPN) #230 verified Resident #64 received oxygen therapy at three liters per minute (l/m) and further confirmed the resident did not have a physician order for oxygen therapy. Review of the oxygen order dated 02/17/26 and timed at 5:32 P.M. for Resident #64 revealed oxygen at two l/m. Review on 02/18/26 of the baseline care plan dated 02/16/26 for Resident #64 revealed no baseline care plan was in place for oxygen therapy. Further review on 02/19/26 of the baseline care plan dated 02/16/26 revealed it was updated to include oxygen at three l/m, then changed to two l/m. Interview on 02/19/26 at 10:54 A.M. with LPN #281 revealed she added the documentation related to oxygen therapy to Resident #64's baseline care plan on 02/18/26 to indicate the resident admitted with oxygen in place. LPN #281 confirmed oxygen therapy was not documented upon admission and was added to the baseline care plan two days after admission. Interview on 02/19/2026 at 1:42 P.M. with the Director of Nursing (DON) verified the oxygen order for Resident #64 was not obtained and written until 02/17/26. Review of the facility policy titled, Medication and Treatment Orders, revised July 2016, revealed orders for medication and treatments would be consistent with principles of safe and effective order writing. All drug and biological order shall be written, dated, and signed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview and policy review the facility failed to wear proper personal protective equipment (PPE) upon entry into a contact precautions room. This affected two (#10 and #47) of two residents reviewed for transmission-based precautions (TBP). The facility census was 56.Findings include: 1. Review of the medical record for Resident #10 revealed the resident was admitted to the facility on [DATE]. Diagnoses included sepsis of unspecified organism, muscle weakness, unsteadiness of feet, hypomagnesium, urinary tract infection (UTI), and unspecified dementia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive deficits. Resident #10 required substantial/maximum assistance with activities of daily living (ADLs). Review of the physician orders revealed an order dated 02/16/26 contact precautions for urine. Observation on 02/17/26 at 9:05 A.M. of signage posted outside of Resident #10's room revealed the resident was in contact precautions. Further observation of the posted signage revealed all providers and staff were to put on gloves and a gown before entry into resident's room. Observation on 02/17/26 at 9:19 A.M. revealed Licensed Practical Nurse (LPN) #291 and LPN #230 entered Resident #10's room without donning a gown. Interview on 02/17/26 at 9:21 A.M. with LPN #230, after exiting Resident #10's room, confirmed a gown was not donned prior to entering the resident's room. LPN #230 stated Resident #10 was on contact precautions for an infection in her urine, so PPE was only needed if coming into contact with the resident's urine. A follow-up interview with LPN #230 and LPN #291 on 02/17/26 at 12:20 P.M. confirmed that neither donned a gown upon entry to Resident #10's room. LPN #230 and LPN #291 confirmed they administered Resident #10's medications, which included intravenous (IV) antibiotics. 2. Review of the medical record for Resident #47 revealed an admission date of 02/28/24 with diagnoses of multiple sclerosis, neuromuscular dysfunction of the bladder, Type II diabetes mellitus, and cellulitis. Review of the MDS assessment, dated 02/05/26, revealed Resident #47 had intact cognition. Review of a physician order dated 02/08/26 revealed Resident #47 was in contact precautions for ESBL (extended-spectrum Beta-Lactamase) (an infection) in urine. Observation on 02/17/26 at 11:15 A.M. revealed signage posted outside of Resident #47's room indicating the resident was on contact precautions. Further obervation of the signage revealed staff must put on gloves and a gown before room entry. No PPE, such as gowns and gloves, was available outside the room. Continued observation revealed Certified Nursing Assistant (CNA) #269 and CNA #242 entered Resident #47's room without donning any PPE. Further observation, upon opening Resident #47's door, revealed both CNAs were wearing gloves and no gowns. Concurrent interview with CNA #269 revealed gowns were located in a bin inside the room near the door to the bathroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Both CNAs proceeded to don gowns. Interview on 02/17/26 at 11:42 A.M. with the Administrator verified the contact precautions signage outside of Resident #47's room stated PPE should be donned prior to entering the resident's room and further confirmed no PPE was available outside of the room. Interview on 02/17/26 at 11:45 A.M. with Resident #47 revealed staff did not routinely wear gowns when they came in the room. During the interview, LPN #291 entered Resident #47's room not wearing a gown or gloves. LPN #291 explained she planned to check Resident #47's blood sugar. LPN #291 entered the bathroom, obtained a pair of gloves (no gown), and proceeded to check Resident #47's blood sugar. Concurrent interview with LPN #291 confirmed she did not don PPE before entering the room. A follow-up interview on 02/17/26 at approximately 11:55 A.M. with LPN #291 confirmed she should have donned a gown and gloves before entering Resident #47's room to perform a blood sugar check. Review of the facility policy titled, Isolation-Categories of Transmission- Based Precautions, dated January 2012, revealed staff were to wear PPE, specifically disposable gloves and gown, upon entering a contact precautions room.