STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366444	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancrest of Ada	600 West North Avenue Ada, OH 45810

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interview, Nurse Practitioner (NP) interview, and review of facility policy, the facility failed to notify the provider and resident representative of a new skin impairment. This affected one (#50) of one resident reviewed for notification of change. The facility census was 48. Findings include:Review of the closed medical record for Resident #50 revealed an admission date of 01/08/25 and a discharge date of 10/31/25. Diagnoses included atrial fibrillation (abnormal heart beat), diabetes mellitus type II, congestive heart failure (CHF), chronic kidney disease (CKD) stage three (CKD is measured in stages one through four, stage four requires renal dialysis), liver cirrhosis, peripheral vascular disease (PVD), bilateral (both sides) below the knee amputation (BKA), and altered mental status.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was cognitively intact and had no unhealed pressure ulcers.Review of the Weekly Wound and Skin Assessment Documentation dated 10/24/25 Resident #50 revealed a dark blanchable redness to the bilateral buttocks. No measurements or other wound characteristics were documented.Review of the physician orders for October 2025 revealed no new wound orders related to the new skin impairment identified on Resident #50's buttocks on 10/24/25. Review of Resident #50's nursing progress notes revealed no evidence the NP, Wound NP, or responsible party were notified of Resident #50's new skin impairment to her buttocks. Interview on 11/03/25 at 8:18 A.M. with Wound NP #420 confirmed she was not notified of the new skin impairment identified on Resident #50's buttocks on 10/24/25. NP #420 further stated she would typically be notified of new skin impairments for follow-up. Interview on 11/05/25 at 10:52 A.M. with NP #415 confirmed she was not notified of the new skin impairment to the bilateral buttocks of Resident #50. NP #415 further stated she rounded on Resident #50 the morning of 10/24/25 and was still in the facility at the time the facility staff identified the skin impairment. Interview on 11/05/25 at 8:12 A.M. with the Director of Nursing (DON) verified the facility had no evidence the NP or resident representative were notified of the new skin impairment identified on Resident #50's buttocks. Review of the facility policy titled, Change in a Resident's Condition or Status, revised February 2021, revealed the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366444	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancrest of Ada	600 West North Avenue Ada, OH 45810

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	366444	A. Building B. Wing	11/06/2025

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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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of hospital records, review of the facility submitted Self-Reported Incident (SRI), review of staff and resident statements, resident and staff interview, and review of the facility policy, the facility failed to ensure residents did not develop avoidable, facility acquired, pressure ulcers. This resulted in actual harm for Resident #50 on 10/24/25 when facility staff placed the resident on a bedpan and failed to check on her and remove her from the bedpan for an extended period of time. Consequently, Resident #50 developed a deep tissue injury (DTI - a type of pressure injury that begins in the deeper tissues and is caused by prolonged pressure) on her buttocks. Additionally, upon discovery of the DTI, the facility failed to thoroughly assess and document the DTI. This affected one (#50) of three residents reviewed for pressure ulcers. The facility census was 48.Findings include:Review of the closed medical record for Resident #50 revealed an admission date of 01/08/25. Diagnoses included atrial fibrillation (abnormal heartbeat), diabetes mellitus Type II, congestive heart failure (CHF), chronic kidney disease (CKD) stage three (CKD is measured in stages one through four, stage four requires renal dialysis), liver cirrhosis, peripheral vascular disease (PVD), bilateral (both sides) below the knee amputation (BKA), and altered mental status (AMS). Resident #50 transferred to the hospital on [DATE] due to AMS and was subsequently discharged from the facility on 10/31/25, without returning following her hospitalization.Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/06/25, revealed Resident #50 was cognitively intact, required moderate (staff) assistance with toileting, had occasional bladder incontinence, and had no unhealed pressure ulcers. Review of the care plan, revised September 2025, revealed Resident #50 required one (staff) assistance for toileting and bed mobility and preferred the use of a bedpan for toileting. Review of Nurse Practitioner (NP) #415's visit note, dated 10/24/25 at 10:24 A.M., revealed Resident #50 was acutely seen for lethargy and AMS. Resident #50's roommate (Resident #32) was at the nursing station and reported the resident had been more confused and the nursing staff validated the concern, and reported Resident #50 had been slow to respond. Further review revealed Resident #50 complained of lower abdominal pain, loose stools, fever (although no documented fever), strong concentrated urine, and concern for a urinary tract infection (UTI). Continued review revealed the resident was positive for a change in activity, increased weakness, decreased concentration, and abdominal pain with loose stools. Resident #50 was ill-appearing, despite being alert and oriented to person, place and time. Resident #50 had a labile affect, delayed speech, and somnolence (state of drowsiness or strong desire to fall asleep). The resident stated she did not feel well. The plan for treatment was to encourage fluids, obtain a urine sample, and a suspected UTI with a plan to treat with ceftriaxone (antibiotic) one gram (gm) intramuscularly (IM) for three days. A stat (immediate) complete blood count (CBC - measures values for possible infection) and basic metabolic panel (BMP - measures electrolyte values, this will indicate dehydration or electrolyte imbalance) were to be completed. If no improvement, send to the emergency department (ED) for evaluation and treatment. Review of the October 2025 physician orders revealed on 10/24/25, Resident #50 had orders for four ounces of water every two hours related to UTI, obtain urinalysis (UA) with reflex (test to identify an infection in the urinary system), CBC, BMP, and ceftriaxone sodium injection one gm IM daily for three days. Review of the Weekly Wound and Skin Assessment Documentation, dated 10/24/25, revealed Resident #50 had a new, dark blanchable redness area to the bilateral buttocks. No wound measurements or characteristics were documented.Review of a nursing progress note, dated 10/24/25 at 12:38 P.M. and authored by Licensed Practical Nurse (LPN) #341, revealed Resident #50 had increased confusion, unclear speech, and incontinent episodes. NP #415 was notified, and orders were obtained for treatment. Review of the ED notes, dated 10/25/25, revealed the attending physician documented that Resident #50 had skin breakdown to the bilateral buttocks. The nurse documented that the nursing facility reported Resident #50 was accidentally left on the bedpan overnight on Thursday (10/23/25 into 10/24/25). Further review of the nursing documentation revealed Resident #50 had a large DTI ring circling the buttocks and the DTI portion on the right buttock was blistered. Further review of the 10/25/25 hospital records revealed a photograph showing the resident's right outer buttock, extending down to the gluteal fold (area where the bottom of the buttock and the top of the posterior thigh begins) was deep red, nearly ruddy, in color. The right outer buttock showed an area that was open, with a deep, dark, nearly purple center of the open area. Review of a second photograph revealed an image of the resident's left buttock that showed a dark red area to the outer buttock