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	02/06/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, review of Medicare beneficiary notice letters, and staff interview, the facility failed to issue Skilled Nursing Facility Advance Beneficiary Notices (SNFABN) to residents. This affected two residents (#24 and #104) of three residents reviewed for Medicare beneficiary notice letters. The census was 51. Findings include: 1. Review of Resident #24's medical record revealed an admitted [DATE]. Diagnoses listed included hemiplegia, type two diabetes mellitus, hypertension, and major depressive disorder. Review of a Notice of Medicare Non-Coverage (NOMNC) dated 10/07/24 revealed Medicare part A services would end on 10/11/24. Further review of Resident #24's medical record revealed he remains in the facility. There was no documentation of a SNFABN being issued to Resident #24 on 10/11/24. 2. Review of Resident #104's closed medical record revealed an admitted [DATE]. Diagnoses listed included atrial fibrillation, type two diabetes mellitus, and muscle weakness. Review of a NOMNC dated 12/16/24 revealed Medicare part A services would end on 12/20/24. Further review of Resident #104's closed medical record revealed she remained in the facility after 12/20/24. There was no documentation of a SNFABN being issued to Resident #104. Resident #104 was discharged from the facility on 01/07/25. During an interview on 02/05/25 at 1:40 P.M. the Administrator confirmed Residents #24 and #104 were not issued SNFABN. The Administrator confirmed both Residents #24 and #104 remained in the facility after Medicare part A services were discontinued and they had not exhausted Medicare part A benefits.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516 Based on medical record review and staff interview, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included minimum healthcare information necessary to properly care for the immediate needs for one resident (#259) of one resident reviewed for baseline care plans. The facility census was 51. Findings include: Review of medical record of Resident #259 revealed an admitted [DATE]. Diagnoses included chronic systolic heart failure. Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #259 was cognitively intact. Review of care plan initiated on 01/13/25 revealed the treatment of Tubigrips (compression stockings) and ace wraps was not added to the care plan Review of physician order dated 01/31/25 revealed to apply Tubigrips size G then wrap over the top with ace wraps every A.M. off P.M. Observation on 02/03/25 at 11:02 A.M. and second observation on 02/04/25 at 1:02 P.M. revealed Resident #259 sitting in recliner in resident's room. Tubigrips (compression stockings) in place bilateral without ace wraps. Ace wraps were on the counter in the resident's bathroom. Interview on 02/03/25 at 11:02 A.M. revealed Resident #259 stated he was told by staff he no longer needed ace wraps on his legs. Interview on 02/04/25 at 1:15 P.M. with Licensed Practical Nurse (LPN) #173 verified Resident #259 did not have ace wraps on bilateral and an order was in place. Interview on 01/13/25 at 1:00 P.M. with Assistant Director of Nursing (ADON) #219 revealed the care plan did not address the treatment of tubigrips and ace wraps in the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, record review, and interview, the facility failed to implement a comprehensive care plan to include all aspects of patient care. This affected one (Resident #1) of 16 residents reviewed for comprehensive care plans. The facility census was 51. Findings include: Review of medical record for Resident #1 revealed an admitted [DATE] with diagnoses including but not limited to hemiplegia/hemiparesis following cerebral infarction affecting right dominant side, rheumatoid arthritis, age-related osteoporosis, muscle weakness, and cerebral infarction. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impairment on both sides for upper body movement and lower body movement. Review of current physician orders revealed no orders for splinting or bracing right hand contracture. Review of discharged physician orders revealed Resident #1 to wear right palm protector throughout the day eight to twelve hours, hand hygiene to be completed pre/post application, apply orthotic during A.M. care routine and remove during P.M. care routine prior to bed time from 09/07/23 through 10/02/23. Review of Occupational Therapy (OT) discharge note dated 12/15/23 revealed resident and staff inconsistent with palm protector application despite continued education and importance of use for contracture management. Review of care plan dated 01/03/25 revealed no care plan regarding contracture's. Observation and interview on 02/03/25 at 10:19 A.M. revealed Resident #1 had a significant contracture to right hand. Resident #1 stated she could open it a little bit. Resident #1 stated that the staff sometimes stretch it and she denied wearing any splints or braces to that hand. Observation and interview on 02/05/25 at 3:21 P.M. revealed Resident #1 resting in bed. No splints or palm protector noted in right hand. Resident #1 stated they used to have a palm protector in place but not recently or for awhile now. Interview on 02/05/25 at 3:15 P.M. with Physical Therapist (PT) #221 revealed she was unsure when Resident #1 was last seen for OT. PT #221 verified Resident #1 had a significant contracture to her right hand. PT #221 stated the resident had the contracture when admitted . Interview on 02/06/25 at 10:18 A.M. with MDS #220 verified Resident #1 did not have a care plan for contracture's or Range of Motion (ROM). MDS #220 verified the resident should have a care plan regarding contracture's.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, record review, interview, and policy review, the facility failed to provide treatment for contracture's. This affected one (Resident #1) of one reviewed for contracture's. The facility also failed to provide treatments per physician order. This affected one (Resident #259) of one reviewed for treatments. The facility census was 51. Findings include: 1. Review of medical record for Resident #1 revealed an admitted [DATE] with diagnoses including but not limited to hemiplegia/hemiparesis following cerebral infarction affecting right dominant side, rheumatoid arthritis, age-related osteoporosis, muscle weakness, and cerebral infarction. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impairment on both sides for upper body movement and lower body movement. Review of current physician orders revealed no orders for splinting or bracing right hand contracture. Review of discharged physician orders revealed Resident #1 to wear right palm protector throughout the day eight to twelve hours, hand hygiene to be completed pre/post application, apply orthotic during A.M. care routine and remove during P.M. care routine prior to bed time from 09/07/23 through 10/02/23. Review of Occupational Therapy (OT) discharge note dated 12/15/23 revealed resident and staff inconsistent with palm protector application despite continued education and importance of use for contracture management. Review of care plan dated 01/03/25 revealed no care plan regarding contracture's. Observation and interview on 02/03/25 at 10:19 A.M. revealed Resident #1 had a significant contracture to right hand. Resident #1 stated she could open it a little bit. Resident #1 stated that the staff sometimes stretch it and she denied wearing any splints or braces to that hand. Observation and interview on 02/05/25 at 3:21 P.M. revealed Resident #1 resting in bed. No splints or palm protector noted in right hand. Resident #1 stated they used to have a palm protector in place but not recently or for awhile now. Interview on 02/05/25 at 3:15 P.M. with Physical Therapist (PT) #221 revealed she was unsure when Resident #1 was last seen for OT. PT #221 verified Resident #1 had a significant contracture to her right hand. PT #221 stated the resident had the contracture when admitted . Interview on 02/06/25 at 9:10 A.M. with Certified Nursing Assistant (CNA) #210 revealed she did not believe the resident had a splint or palm protector for her hands. CNA #210 looked in the CNA care book revealing no mention of any splint or palm protectors for Resident #1. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51516 2. Review of medical record of Resident #259 revealed an admitted [DATE]. Diagnoses included chronic systolic heart failure. Review of the 5-day MDS assessment dated [DATE] revealed Resident #259 was cognitively intact. Review of physician order dated 01/31/25 revealed to apply Tubigrips size G then wrap over the top with ace wraps every A.M. off P.M Observation on 02/03/25 at 11:02 A.M. and second observation on 02/04/25 at 1:02 P.M. revealed Resident #259 sitting in recliner in resident's room. Tubigrips (compression stockings) in place bilateral without ace wraps. Ace wraps were on the counter in the resident's bathroom. Interview on 02/03/25 at 11:02 A.M. revealed Resident #259 stated he was told by staff he no longer needed ace wraps on his legs any longer. Interview on 02/04/2025 at 1:15 P.M. with Licensed Practical Nurse (LPN) #173 verified Resident #259 did not have ace wraps on bilateral and had an order to place ace wrap bilateral on top of tubigrips daily for edema.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, observation, and staff interview, the facility failed to ensure an ordered safety intervention was in place for a resident. This affected Resident #21 of four reviewed for accidents. The census was 51. Findings include: Review of Resident #21's medical record revealed an admitted [DATE]. Diagnoses listed include hypertension, psychotic disturbance, and severe dementia without behavioral disturbance. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had severe cognitive impairment. Review of the care plan dated 09/13/23 revealed Resident #21 had an activities of daily living (ADL) self care performance related to her severe dementia. Resident #21 required supervision and cueing for eating. The care plan was updated after 01/17/25 to add an intervention for a Kennedy cup (spill proof cup) was to be used for hot liquids. Review of progress notes revealed on 01/17/25 at 8:30 A.M. Resident #21 reached for her hot chocolate and spilled it on her upper thighs while the Certified Nursing Assistant (CNA) was placing a shirt protector. Redness and a blisters appeared on Resident #21's left thigh. Silvadene (burn treatment cream) was ordered by physician. Review of physician orders revealed an order dated 01/17/25 to use a Kennedy cup for hot liquids. Observation on 02/02/25 at 12:55 P.M. revealed Resident #21 was sitting at a dining room table. Resident #21 had a cup of hot chocolate without lid. The cup was not a Kennedy cup. No staff were currently assisting Resident #21 with her meal or sitting near. Interview with Certified Nurse Aide (CNA) #211 on 02/04/25 at 12:55 P.M. confirmed Resident #21 did not have a Kennedy cup with her hot chocolate. CNA #211 stated that she did not know Resident #21 required a Kennedy cup for her hot drinks. Interview with the Director of Nursing (DON) on 02/04/25 at 1:00 P.M. confirmed Resident #21 had an order for Kennedy cups for hot liquids and that Resident #21 had recently burned herself by spilling hot chocolate.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, observation, interview, and policy review the facility failed to ensure oxygen tubing was changed per physician order. This affected three (Residents #7, #22, and #23) of five residents reviewed for oxygen. The facility census was 51. Findings include: 1. Review of medical record for Resident #7 revealed an admitted [DATE] with diagnoses including but not limited to asthma. Review of current physician orders revealed oxygen tubing/equipment to be changed/cleansed weekly. Observation on 02/03/25 at 10:40 A.M. revealed oxygen tubing dated 01/04/25. Interview on 02/03/25 at 10:41 A.M. with Certified Nursing Assistant (CNA #209) verified the oxygen tubing was dated 01/04/25. 2. Review of medical record for Resident #22 revealed an admitted [DATE] with diagnoses including but not limited to personal history of pulmonary embolism, dementia, and atherosclerotic heart disease. Review of current physician orders revealed change oxygen tubing on Thursdays. Observation on 02/03/25 at 9:58 A.M. of oxygen concentrator in the bathroom revealed oxygen tubing was dated 01/16/25. Oxygen running at two liters via nasal cannula. Interview on 02/02/25 at 10:06 A.M. with CNA #209 verified the oxygen tubing was dated 01/16/25. 3. Review of medical record for Resident #23 revealed an admitted [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease. Review of current physician orders revealed oxygen tubing/equipment to be changed/cleansed weekly. Observation on 02/03/25 at 10:13 A.M. revealed oxygen tubing dated 01/24/25. Interview on 02/03/25 at 10:13 A.M. with CAN #181 verified the oxygen tubing was dated 01/24/25. Review of policy titled, Oxygen Therapy-Mask and Cannula, not dated revealed when cannula becomes soiled with secretions, it needs to be changed. 10:00 P.M. - 6:00 A.M. shift changes all oxygen supplies weekly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on medical record review, staff interview, and review of information from Medscape, the facility failed to follow pharmacy recommendation for one resident (#25) of five reviewed for unnecessary medications resulting in an unobserved medication error. The facility census was 51. Findings include. Review of the medical record of Resident #25 revealed an admitted [DATE]. Diagnoses included anemia, gastroesophageal reflux disease, migraines, and angina pectoris. Review of the physician orders dated 07/08/24 revealed orders for Topamax (migraines) 25 milligrams (mg) twice daily, Protonix 40 mg daily, Isosorbide mononitrate extended release 40 mg daily, and ferrous sulfate 325 mg daily. Review of a pharmacy recommendation dated 08/02/24 revealed a recommendation to consider holding or discontinuing the medications if crushing becomes necessary long-term. The document was indicated as agree and signed by the physician. Interview on 02/05/25 at 11:20 A.M. with Licensed Practical Nurse #167 revealed she crushes all of Resident #25's medications as Resident #25 will spit out any whole medications. LPN #167 was unaware the medications should not be crushed. Review of medication information from Medscape at https://www.medscape.com/nurses revealed Protonix is a proton pump inhibitor, Topamax is a anticonvulsant, Isosorbide mononitrate is a nitrate and Ferrous Sulfate is a iron supplement. Further review of Medscape revealed these medications should be swallowed whole and should not be split, crushed, or chewed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516 Based on record review, staff interview, policy review and review of medication information from Medscape, the facility failed to ensure a resident was free from unnecessary medications regarding having an adequate indication of use for a long-term antibiotic. This affected one (#40) out of five resident reviewed for antibiotic stewardship. The facility census was 51. Findings include: Review of medical record for Resident #40 revealed an admitted [DATE] with diagnoses of dementia with behavioral symptoms, major depressive disorder, malnutrition, cognitive communication deficit, and anxiety. Resident #40 does not have a diagnosis of chronic urinary tract infections (UTI). Further review of the medical record revealed Resident #40 had a urinalyses with culture on 05/06/24 with Cipro (antibiotic) 250 milligrams (mg) two times a day for seven days ordered on 05/12/24 for UTI. A urinalysis with culture on 06/05/24 with Microbid 10 mg two times a day for seven days ordered on 06/10/24 for UTI. A urinalysis with culture on 06/24/24 with Amoxicillin 500 mg two times a day for five days ordered on 06/28/24 for UTI. Daughter states Resident #40 was on daily Cipro for UTI prophylaxis in the past. Daughter also mentions that Resident #40 typically gets diarrhea when on an antibiotic and request for Resident #40 to be placed on an antibiotic prophylaxis. Cephalexin oral suspension reconstituted 250 mg/5milliliter (ml), 2.5 ml by mouth one time a day, daily for UTI prevention and cranberry 250 mg daily was ordered on 07/02/24. Resident #40 was not diagnosed with a UTI when she was started on cephalexin, she did not have a stop date, and managment team never discussed stopping antibodic with doctor. Interview on 02/06/25 at 2:15 P.M. with Infection Disease Nurse #219 revealed no Time Out Sheet (a form the facility has for the provider to fill out for over use of medication is noticed) on Resident #40. Infection Disease Nurse #219 stated a time out sheet was not needed in Resident #40's case because the family requested her to be placed on the antibiotic. Infection Disease Nurse #219 confirmed cephalexin is not indicated for prolonged use. Review of policy titled, Antibiotic Stewardship, undated, revealed the prescribers will complete antibiotic order including the following elements: drug name, dose, frequncy of administration, duration of treatment including start and stop date or number of days of therapy, route of administration and indications of use. Review of medication information from Medscape at https://reference.medscape.com/drug/keflex-cephalexin-342490 revealed cephalexin is a 1st generation cephalosporin antimicrobial used to treat infections. Further review of Medscape revealed prolonged use of cephalexin is associated with fungal or bacterial superinfection.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, Novolog insert, and staff interview, the facility failed to ensure insulin pen was primed resulting in a significant medication error. This affected one resident (#15) of one reviewed for insulin administration. The facility census was 51. Findings include: Review of medical record for Resident #15 revealed an admitted [DATE] with diagnoses including but not limited to urinary tract infection, paroxysmal atrial fibrillation, and type two diabetes without complications. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #15 received insulin injections three days out of seven during look back period. Review of current physician orders revealed Lantus SoloStar pen injector 100 unit/milliliter inject six units subcutaneously (SQ) daily at 8:00 P.M., Novolog FlexPen SQ solution pen injector 100 unit/milliliter inject per sliding scale if 0-150 no insulin, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-500 = 12 units call physician if blood sugar is greater than 400 before meals and at bedtime. Observation on 02/04/25 at 11:01 A.M. of insulin administration for Resident #15 revealed LPN #173 checked the residents blood sugar with a result of 208. LPN #173 checked the sliding scale on the medication administration record (MAR) and revealed the resident was to receive 4 units. LPN #173 removed the residents Novolog FlexPen from the cart, placed a needle on the pen, and proceeded to dial 4 units to the pen. LPN #173 entered the residents room and donned gloves, cleaned area on abdomen with alcohol wipe, removed cap from the needle on the pen and injected the insulin into the resident's abdomen. LPN #173 did not prime the insulin pen with two units prior to dialing up the dose to give to the resident per manufacturer recommendations. Interview on 02/04/25 at 11:08 A.M. with LPN #173 verified she did not prime the insulin pen prior to dialing up the ordered dose. LPN #173 stated she did not know you had to prime the pen every time you used it. Review of package insert for Novolog FlexPen revealed for each injection select a dose of two units, take off the outer needle cap, and the inner needle cap, with the pen pointing up, tap the insulin to move the air bubbles to the top, press the button all the way in and make sure insulin comes out of the needle, repeat up to two more times with the same needle if needed. If insulin does not come out after three times, change the needle and try again. If insulin still does not come out after changing the needle, the pen may be broken.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35031 Based on observation, staff interview, and scoop size chart, the facility failed to follow the menu for pureed diets. This affected three residents (#02, #04, and #35) identified by the facility as receiving a puree diet. The facility census was 51. Findings include: Observation on 02/07/25 at 11:45 A.M. revealed [NAME] #110 serving the meal. [NAME] #110 did not have a spreadsheet to indicate correct portion sizes. [NAME] #110 used a blue handled scoop to portion the pureed chicken onto the plates. Upon questioning the portion amount, [NAME] #110 did not know the amount the scoop provided. [NAME] #00 further did not serve any bread to the three residents. Upon interview with [NAME] #110, she responded the facility does not serve bread to puree diets as it just clumps. Review of the menu for Tuesday revealed the lunch to consist of Italian chicken breast, AuGratin potatoes, cauliflower, dinner roll, and apple cake. Review of the spreadsheet dated 02/04/25 revealed the pureed diet was to receive a number eight scoop (grey-handled, 1/2 cup). The menu further did not have any portion size for the dinner roll. Review of the scoop size chart revealed the blue-handled scoop portioned out one quarter cup of product. The grey-handled scoop would have portioned out one half cup.

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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. 35031 Based on observation, staff interview, and policy review, the facility failed to maintain a clean and sanitary kitchen environment. This had the potential to affect all 37 residents residing in the facility. The facility census was 51. Findings include: Observation on 02/03/25 beginning at 8:40 A.M. revealed the kitchen floor surrounding the deep fryer had a thick amount of grease as well as both left and right sides of the deep fryer; the handles of the oven had a large amount of dried food substances; the shelf above the range was covered in aluminum foil but black with foods and grease; the two shelves above the steam table had a moderate film of grease build-up; the top of the convection oven had a thick film of black grease; and the ice scoop was stored inside the machine on top of the ice. Interview on 02/03/25 at 9:00 A.M. with [NAME] #110 verified the above findings. Review of the policy titled, Sanitization, dated 11/22, revealed all kitchens and kitchen areas are kept clean and free from debris.

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	02/06/2025

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 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** 45751 Based on observation, interview, and policy review, the facility failed to ensure proper infection control practices during medication pass. This affected two residents (#1 and #15) of four residents reviewed for medication administration. The facility census was 51. Findings include: 1. Review of medical record for Resident #1 revealed an admitted [DATE] with diagnoses including but not limited to methicillin resistant staphylococcus aureus (MRSA) infection as the cause of diseases classified elsewhere, unspecified open wound of abdominal wall, urinary tract infection, and cerebral infarction. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment. Resident #1 received intravenous antibiotics (IV ATBs) with IV access. No isolation per MDS. Review of current physician orders revealed change peripherally inserted central catheter (PICC) line dressing every week on Thursday, contact isolation related to MRSA, and vancomycin IV one gram intravenously daily for MRSA. Observation on 02/04/25 at 10:06 A.M. of IV administration for Resident #1 revealed Licensed Practical Nurse (LPN) #101 donned gloves prior to entering room. LPN #101 cleansed PICC port with alcohol pad, flushed IV with 10 milliliters of normal saline, attached the ATB ball to the port and placed the ball into the holder on the back of the wheelchair. LPN #101 cleaned up area and removed gloves and washed hands. Interview on 02/04/25 at 10:15 A.M. with LPN#101 verified she did not don a gown prior to entering the room to a resident in contact isolation for MRSA to hang IV medication through a PICC line. Review of policy titled, Isolation-Categories of Transmission-Based Precautions, revised January 2012 revealed contact isolation used for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether precautions are necessary will be evaluated on a case by case basis. Gown: wear a disposable gown upon entering the contact precaution room or cubicle. After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces. 2. Review of medical record for Resident #15 revealed an admitted [DATE] with diagnoses including but not limited to urinary tract infection, paroxysmal atrial fibrillation, and type two diabetes without complications. Review of the MDS assessment dated [DATE] revealed the resident is cognitively intact. Resident #15 received insulin injections three days out of seven during look back period. (continued on next page)

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	02/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of current physician orders revealed Lantus SoloStar pen injector 100 unit/milliliter inject six units subcutaneously (SQ) daily at 8:00 P.M., Novolog FlexPen SQ solution pen injector 100 unit/milliliter inject per sliding scale if 0-150 no insulin, 151-200 =2 units, 201-250 =4 units, 251-300 =6 units, 301-350 =8 units, 351-400 =10 units, 401-500 =12 units call physician if blood sugar is greater than 400 before meals and at bedtime. Observation on 02/04/25 at 11:07 A.M. following blood sugar check with glucometer, revealed Licensed Practical Nurse (LPN) #173 placed the glucometer on the medication cart, donned gloves, and cleaned the glucometer with an alcohol pad and placed on a paper towel. LPN #173 removed gloves and sanitized hands. Interview on 02/04/25 at 11:08 A.M. with LPN #173 verified she cleaned the glucometer with an alcohol wipe. LPN #173 verified the facility uses the same glucometer for each resident on the 200 hallway that require blood sugar readings. Review of policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment revised on September 2022 revealed reusable items are cleaned and disinfected or sterilized between residents. Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions.

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	02/06/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516 Based on record review, staff interview, policy review, and review of information from Medscape, the facility failed to conduct ongoing review for antibiotic stewardship. This affected one (#40) out of five resident reviewed for antibiotic stewardship. The facility census was 51. Findings include: Review of medical record for Resident #40 revealed an admitted [DATE] with diagnoses of dementia with behavioral symptoms, major depressive disorder, malnutrition, cognitive communication deficit, and anxiety. Resident #40 does not have a diagnosis of chronic urinary tract infections (UTI). Further review of the medical record revealed Resident #40 had a urinalyses with culture on 05/06/24 with Cipro (antibiotic) 250 milligrams (mg) two times a day for seven days ordered on 05/12/24 for UTI. A urinalysis with culture on 06/05/24 with Microbid 10 mg two times a day for seven days ordered on 06/10/24 for UTI. A urinalysis with culture on 06/24/24 with Amoxicillin 500 mg two times a day for five days ordered on 06/28/24 for UTI. Daughter states Resident #40 was on daily Cipro for UTI prophylaxis in the past. Daughter also mentions that Resident #40 typically gets diarrhea when on an antibiotic and request for Resident #40 to be placed on an antibiotic prophylaxis. Cephalexin oral suspension reconstituted 250 mg/5milliliter (ml), 2.5 ml by mouth one time a day, daily for UTI prevention and cranberry 250 mg daily was ordered on 07/02/24. Resident #40 was not diagnosed with a UTI when she was started on cephalexin, she did not have a stop date, and managment team never discussed stopping antibodic with doctor. Interview on 02/06/25 at 2:15 P.M. with Infection Disease Nurse #219 revealed no Time Out Sheet (a form the facility has for the provider to fill out for over use of medication is noticed) on Resident #40. Infection Disease Nurse #219 stated a time out sheet was not needed in Resident #40's case because the family requested her to be placed on the antibiotic. Infection Disease Nurse #219 confirmed cephalexin is not indicated for prolonged use. Review of policy titled, Antibiotic Stewardship, undated, revealed the prescribers will complete antibiotic order including the following elements: drug name, dose, frequncy of administration, duration of treatment including start and stop date or number of days of therapy, route of administration and indications of use. Review of medication information from Medscape at https://reference.medscape.com/drug/keflex-cephalexin-342490 revealed cephalexin is a 1st generation cephalosporin antimicrobial used to treat infections. Further review of Medscape revealed prolonged use of cephalexin is associated with fungal or bacterial superinfection.