

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Vancrest of Payne		STREET ADDRESS, CITY, STATE, ZIP CODE 650 North Main Street Payne, OH 45880	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident family interview, staff interviews, review of facility self-reported incidents (SRIs), and review of facility policy, the facility failed to report an allegation of injury of unknown origin. This affected one (#35) of two residents reviewed for abuse. The facility census was 37. Findings include: Review of the medical record revealed Resident #35 was admitted on [DATE] and discharged on 11/07/25. Diagnoses included Alzheimer's disease with early onset, age related osteoporosis without current pathological fracture, anxiety disorder, circadian rhythm sleep disorder, and dementia in other diseases classified elsewhere moderate with anxiety. Review of the Minimum Data Set (MDS) assessment, dated 11/07/25, revealed the resident was severely cognitively impaired. The resident was always continent of bowel and bladder. Resident #35 required supervision assistance with toileting and showering and set-up/clean-up assistance with upper and lower body dressing and footwear. Review of a nursing progress note, dated 09/29/25 at 6:27 A.M., revealed Resident #35 had a bruise to the left hand, measuring approximately 5 centimeters (cm) in size, and left shoulder discoloration, approximately 3 cm x 2.5 cm. Observation on 09/29/25 at 10:24 A.M. revealed Resident #35's left hand was swollen and purple in color. Concurrent interview with Resident #35 and her spouse revealed the resident was unable to explain what happened. Resident #35's spouse stated the resident's left hand had a new bruise today and the nurse was aware. Review of the facility submitted SRIs, completed prior to 09/30/25, revealed no SRI was submitted to the state survey agency (SSA) for an injury of unknown origin for Resident #35. Interview on 09/30/25 at 8:24 A.M. with Licensed Practical Nurse (LPN) #171 verified on 09/29/25 Resident #35's hand was swollen and purple and the resident was not able to explain what had occurred. LPN #171 stated she asked some second shift staff and they did not know what happened. Interview on 09/30/25 at 8:35 A.M. with the Director of Nursing (DON) verified it was unknown how the injury to Resident #35's left hand and shoulder had occurred. The DON stated it was reported the resident was unsteady on 09/29/25 and it potentially could have occurred from her running or falling into things. The DON verified not completing a SRI for an injury of unknown origin. A subsequent review of the facility submitted SRIs revealed on 09/30/25 at 11:27 A.M. (after surveyor identification) an SRI was submitted to the SSA for Resident #35's injury of unknown origin. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, dated 2017, revealed an injury of unknown source was when both of the conditions were met: the source of the injury was not observed by any person or could not be explained by the resident and the injury was suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. All incidents and allegations of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and all injuries of unknown source must be reported immediately to the Administrator or designee. The Administrator or designee will notify the Ohio Department of Health (SSA) of all alleged violations involving the above no later than 24 hours from the time the incident/allegation was made known to the staff member.		

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure newly identified skin impairments were thoroughly evaluated and assessed. This affected one (#24) of one resident reviewed for pressure ulcers. The facility census was 37. Findings include: Review of the medical record revealed Resident #24 was admitted on [DATE] and discharged on 11/22/25. Diagnoses included urinary tract infection, atherosclerotic heart disease of native coronary artery without angina pectoris, cognitive communication deficit, major depressive disorder, essential hypertension, hyperlipidemia, primary osteoarthritis, hypotension, type two diabetes mellitus without complications. Review of the Minimum Data Set (MDS) assessment, dated 09/15/25, revealed the resident was moderately cognitively impaired, dependent for toileting and was always incontinent of bladder. Review of the care plan, dated 04/16/25, revealed the resident was care planned for abrasions and pressure ulcers. Review of the physician orders, dated 08/14/25 to 08/18/25, revealed an order to apply triad paste to coccyx area every shift for a superficial open area, with instructions to apply small amount of paste and gently rub in. Further review of the medical record revealed no assessment of the area identified to the coccyx, including a description of the wound or measurements, was completed until 08/18/25 when wound care assessed the area. Review of the Treatment Administration Record from 08/14/25 through 08/18/25 verified the triad treatment was applied as ordered. Interview on 09/30/25 at 3:00 P.M. with the Director of Nursing (DON) verified Resident #24's coccyx wound was not thoroughly assessed upon identification. The DON confirmed that based on the documentation, the wound was identified on 08/14/25 and not assessed until 08/18/25. Review of the facility policy titled, Pressure Ulcer Risk Assessment and Management, dated 10/25/16, revealed to communicate to the wound care nurse/designee any areas of skin breakdown for continued follow up and obtain measurements, including width, length, and depth.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure bed hold notices were provided timely. This affected four (#1, #3, #11, and #38) of four residents reviewed for bed hold notices. The facility census was 37. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date of 01/16/25 with diagnoses including, but not limited to, atrial fibrillation, major depressive disorder, hydronephrosis with renal and ureteral calculus obstruction, anxiety disorder, and congestive heart failure. Review of Minimum Data Set (MDS) assessment, dated 07/21/25, revealed the resident was cognitively intact. Review of a health status note dated 01/30/25 at 10:41 A.M. revealed Resident #1 was transferred to the emergency room (ER) due to blood in her stool. Review of a Communication - with Family/Next of Kin (NOK)/Power of Attorney (POA) note dated 01/31/25 at 9:23 A.M. revealed the resident's daughter did not want to do a bed hold. The resident's daughter stated they cleared out the resident's room last night. The resident's daughter voiced understanding of not doing the bed hold. A bed hold letter was mailed to the resident's daughter via certified mail. Review of the bed hold notice revealed it was not sent to Resident #1's representative until 01/31/25 (resident transferred to the hospital on [DATE]). Review of a nursing note dated 03/14/25 revealed Resident #1 was transferred to the hospital at 8:53 A.M. Review of a Communication- with Family/NOK/POA note dated 03/17/25 at 11:33 A.M. revealed a voicemail message was left for Resident #1's daughter to return the call. A bed hold letter was mailed via certified mail. Review of the bed hold notice revealed it was not sent to Resident #1's representative until 03/17/25 (three days after transfer to the hospital). Review of nursing note dated 06/02/25 revealed at 9:50 A.M., Resident #1 was transferred to the hospital and the resident's daughter was informed of the transfer at 9:55 A.M. Review of a Communication- with Family/NOK/POA note dated 06/02/25 at 1:55 P.M. revealed Resident #1's daughter was contacted and informed the transfer notice would be sent via certified mail. The resident's daughter was informed the resident had used ten out of thirty days of Medicaid bed hold days. The resident's daughter verbalized understanding. Review of the bed hold notice revealed it was sent to Resident #1's representative on 06/04/25 (two days after transfer to the hospital). Interview on 09/30/25 at 2:16 P.M. with the Administrator revealed bed hold notices were sent via certified mail. The Administrator verified the bed hold notices were not provided until after the resident was admitted to the hospital, adding it was her understanding they did not have to be provided unless a resident was admitted. The Administrator confirmed she was unaware that bed hold notices were to be sent with the resident upon transfer to the hospital, or within 24 hours of the transfer. 2. Review of the medical record for Resident #3 revealed an admission date of 06/09/25 with diagnoses including, but not limited to, unspecified fracture of upper end of left humerus, fracture of right femur, hypertension, dementia, anxiety, and congestive heart failure. Review of the MDS assessment, dated 09/01/25, revealed the resident had severe cognitive impairment. Review of a nursing note dated 08/14/25 revealed Resident #3 was transferred to the ER at 9:43 P.M. Review of communication-with Family/NOK/POA dated 08/15/25 at 1:03 P.M. revealed POA notified regarding bed hold for the resident. Explained that a certified letter would be mailed. Writer sent certified bed hold letter. Review of the bed hold notice revealed it was sent via certified mail to Resident #3's POA on 08/15/25 (one day after transfer). Review of nursing note dated 09/14/25 at 7:29 P.M. revealed on-call notified of the resident's request to be sent to the ER and the resident's condition. Son to send family member over to be with the resident in the ER. Review of a Communication-with Family/NOK/POA note dated 09/15/25 at 1:13 P.M. revealed bed hold discussed with Resident #3's son. Resident #3 had used eight out of thirty bed hold days. Son verbalized understanding and a certified letter was mailed to the son. Review of the bed hold notice revealed it was not sent to Resident #3's POA until 09/15/25 (one (continued on next page)		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	day after transfer to the hospital). Interview on 12/22/25 at 3:54 P.M. with the Administrator verified bed hold notices were not provided for Resident #3 until the day after the resident was transferred to the hospital. 3. Review of the medical record for Resident #11 revealed an admission date of 02/24/25 with diagnoses including, but not limited to, heart failure, angioneurotic edema, depression, anxiety, constipation, insomnia, presence of left artificial should joint, and hypertension. Review of the MDS assessment, dated 10/10/25, revealed the resident had severe cognitive impairment. Review of a nursing note dated 05/30/25 at 10:05 P.M. revealed Resident #11 was in much discomfort and had blood in his brief, with a history of hemorrhoids. Resident #11 requested to go the the hospital and POA agreed. Review of a Communication-with Family/NOK/POA note dated 06/03/25 at 1:04 P.M. revealed the writer spoke with Resident #11's POA regarding bed hold. POA stated the resident should be returning in the next few days, so they wanted to do the bed hold. A certified bed hold letter was sent to the POA. Review of the bed hold notice revealed it was mailed on 06/03/25 (four days after transfer to the hospital). Interview on 12/23/25 at 11:24 A.M. with the Administrator verified the bed hold notice for Resident #11 was not provided until four days after transfer to the hospital. 4. Review of the medical record for Resident #38 revealed an admission date of 05/10/25 with diagnoses including, but not limited to, atherosclerotic heart disease of native coronary artery, cerebral infarction, type two diabetes, hypertension, and heart failure. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of a nursing note dated 06/05/25 at 1:28 A.M. revealed at approximately 12:45 A.M. staff were conducting rounds and the resident was groaning out and not following commands. Updated on-call and a new order was received to send to the ER. Review of a Communication/NOK/POA note dated 06/06/25 at 10:05 A.M. revealed the resident's son was updated regarding bed hold for the resident. The son stated the hospital made it seem like the resident would possibly return to the facility either today or tomorrow. Son stated that if this was the case, they would want to hold the bed. Son stated he would call back in the afternoon to let the writer know for sure. The resident is still in observation for now. Review of the bed hold notice revealed it was mailed on 06/09/25 (four days after the resident transferred to the hospital). Interview on 12/23/25 at 11:24 A.M. with the Administrator verified Resident #38's bed hold notice was not provided until four days after transfer to the hospital. Review of the facility policy titled, Bed-Holds and Returns, revised October 2022, revealed all residents/representatives were provided written information regarding the facility and state bed hold policies, which addressed holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, were provided with written notice about these policies at least twice: notice one well in advance of any transfer (admission packet) and notice two at the time of the transfer (or, if the transfer was an emergency, within 24 hours).		