STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365437	a. building _____ b. wing _____	07/09/2025

name of provider or supplier	street address, city, state, zip code
VANCREST OF URBANA, INC	2380 ST RT 68 S URBANA OH, 43078

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F 0000	INITIAL COMMENTS COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00167159 AND COMPLAINT NUMBER OH00166581 AND COMPLAINT NUMBER OH00164646 FOCUSED INFECTION CONTROL SURVEY ADMINISTRATOR: Brenda Newman, LNHA #7676 CERTIFIED BED CAPACITY: 75 CENSUS IN HOUSE: 61 The following deficiencies are based on the Focused Infection Control Survey and complaint investigation completed on 07/09/25.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

NATALIE.HILL | 07/31/2025

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.

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F 0689	Continued From page 1	F 0689		
F 0689 SS=G	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This STANDARD is not met as evidenced by: Based on medical record review, review of hospital records, staff interview, and review of the facility policy, the facility failed to ensure staff safely transferred residents via mechanical lift. This resulted in Actual Harm to Resident #19 on 06/06/25 when staff transferred the resident into a recliner via Hoyer lift. The Hoyer lift was not wide enough to accommodate Resident #19's recliner and the bar of the lift swung back and struck the resident in the forehead causing bruising and a laceration to her forehead which required an emergency room visit and repair with sutures. This affected one (Resident #19) of three residents reviewed for accidents. The facility also failed to prevent resident falls and failed to thoroughly investigate resident falls. This affected one (Resident #25) of three residents reviewed for falls. The facility census was 61 residents. Findings include:	F 0689	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #19 has been assessed and evaluated for appropriate transferring techniques, per facility policy, on multiple dates (note attached audit of completion). Through ongoing assessment, resident has been transferred, with no difficulty, and without injury obtained. Patient denies any concerns/discomfort with transferring techniques concluded. The oversized recliner was removed prior to survey initiation, per family request. Hospice provider has been advised to provide ample amount of time/notification for DME changes/removal to allow for appropriate transition of resident. Resident #25 has been interviewed for bed mobility preferences. Resident states he prefers to be a two person assist despite his ability to complete tasks with one individual. Residents plan of care has been updated to identify specifics of patient preference (note attached). Facility staff educated on change of care, same date (included for reference). How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken: Managerial personnel will conduct random audits of bed mobility tasks and transfer completion guided per each individual's plan of care. Audits will be assessed daily, on each unit, at random time intervals x 1 week, twice weekly x 2 weeks, and once per week x 4 weeks. If concerns are identified, those individuals will be re-educated of the facilities transfer policy and procedures with hands on guidance to be done. Initiation of a Performance	07/18/2025

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F 0689	Continued From page 2 1. Review of the medical record for Resident #19 revealed an admission date of 07/29/23 with diagnoses including displaced fracture of base of neck of left femur, contracture of lower leg muscle, and osteoarthritis. Review of the Minimum Data Set (MDS) assessment for Resident #19 dated 06/02/25 revealed the resident had severe cognitive impairment, had functional limitations to the bilateral lower extremities, and was dependent on staff assistance with all transfers. Review of the incident report for Resident #19 dated 06/06/25 timed at 9:30 A.M. revealed staff were transferring resident to the recliner when Hoyer legs would not stretch wide enough to accommodate the recliner. Staff continued to use the Hoyer lift to lower the resident into the recliner. As the staff were lowering Resident #19 into the recliner, the Hoyer lift snapped back and hit the resident on the head causing a laceration. Resident #19 was sent to the emergency room (ER). Review of the progress note for Resident #19 date 06/06/25 timed at 10:43 A.M. revealed two Certified Nursing Assistants (CNAs) reported the resident sustained a laceration to the head during a Hoyer lift transfer when the legs of the lift did not stretch wide enough for the recliner causing the lift to snap back resulting in the resident sustaining the laceration as they were lowering the resident into the	F 0689	Improvement Plan will be conducted, as needed. What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur: Upon admission, each resident shall be assessed for safe transfers/ bed mobility tasks guided per the functional status and personal preference expressed. Activities of daily living will be re-assessed quarterly, as needed, and with any significant medical changes following the initial admit, per facility designee, and will be reflected on the individualized plan of care. How the corrective actions will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place; and dates when corrective action will be completed. This plan of correction will be implemented, and the corrective action will be evaluated for its efficiency. The plan of correction is integrated into the facilities Quality Assurance Program. All auditing tools will be completed, as dictated, with thorough review. Any adverse findings/trends noted, will be corrected immediately and brought to the Quality Assurance and Performance Improvement Committee for review. Please consider this plan of correction to be an allegation of compliance as if 07-18-2025 Resident #19's most recent assessment was done on 07/18/2025, which was completed by nurse on the unit. Hospice nurse was notified the date of the incident, which was 06/06/2025. The Director of Nursing, unit managers and maintenance director reviewed wheelchairs and personal chair sizes to ensure mechanical lifts meet manufacture guidelines when in use. No concerns were	

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F 0689	Continued From page 3 recliner. Review of the progress note for Resident #19 dated 06/06/25 timed at 1:30 P.M. revealed the resident returned from the ER with a suture to a laceration to the resident's left upper forehead. The resident also had some purple bruising to the forehead. Review of the care plan for Resident #19 updated 06/06/25 revealed the resident sustained a skin tear and a laceration to her head during a Hoyer lift transfer. Interventions included staff should use caution during transfers and bed mobility to prevent striking the resident's arms, legs, and hands against any sharp or hard surface. Review of the hospital records for Resident #19 dated 06/06/25 revealed the resident arrived in the ER with a head injury sustained when staff at the nursing home transported the resident to a recliner via Hoyer lift. Resident sustained a head injury without loss of consciousness when she was struck in the head with a metal pole from the left. Resident #19 had significant bleeding and receives Xarelto (a blood thinner) for treatment of atrial fibrillation. Lidocaine with epinephrine was applied to the injured area and the laceration was repaired with one suture applied. Review of the interdisciplinary team (IDT) investigation of the incident involving	F 0689	identified, and audit was completed the week of survey. Mechanical lift inspections our done monthly by maintenance director. Maintenance Director reports any adverse findings to the Director of Nursing. A thorough investigation was completed per interdisciplinary team on 04/14/2025, which included Director of Nursing, Unit Manager, and MDS nurse. Initial interview incident was conducted per agency nurse at time of fall. Subsequent communication completed on 04/14/2025 per Unit Manager. In clinical care meeting on 04/14/25 resident #25 incident reviewed including preference stated by resident and during that time resident did not express any concerns with changes in the plan of care. During plan of correction review resident was reinterviewed and express the desire to have two staff assist during bed mobility this time forward, which was 07/22/25. Plan of care updated with the following information. Yes, each fall investigation is led by the Director of Nursing and reviewed with the clinical team. The new processes were put into place and the implementation of the IPRO fall tracking tool along side current facility policy and procedures for incident investigations. The licensed nurse's staff and STNA are educated on transferring techniques including Hoyer lift policy and procedure at time of hire, annually, and with any manufacture changes or new equipment. Upon hire would be our HR representative, annually or any changes would be completed by managerial nursing staff. Maintenance Director supplies any information regarding new lifts introduce into the facility. All nurses are oriented upon hire	

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F 0689	Continued From page 4 Resident #19 dated 06/09/25 revealed two aides assisted the resident to the recliner via Hoyer lift. During the transfer the legs of the Hoyer lift would not extend to the width of the recliner due to the size of the chair. The Hoyer device made contact with resident's head causing a laceration. Resident #19 was sent to the ER and returned with a suture to the laceration to the forehead. Resident #19 typically rested in a geri chair when out of bed but was in the process of getting a new chair from the hospice provider, and the recliner was used instead on 06/06/25. The facility follow up included to not utilize the recliner for Resident #19 because the Hoyer legs could not spread wide enough for the resident to safely transfer and to educate staff on the resident's care plan and appropriate Hoyer usage. Interview on 07/02/25 at 2:00 P.M. with the Director of Nursing (DON) confirmed on 06/06/25 two CNAs transferred Resident #19 to her recliner with a Hoyer that was too small to accommodate the width of the recliner. The DON confirmed staff continued with the transfer even when they became aware the Hoyer lift was not the correct size to complete the transfer. The DON confirmed as the staff lowered Resident #19 into the recliner, the bar of the Hoyer lift swung back and hit the resident in the head. Resident #19 sustained a laceration and bruising to the left forehead which resulted in the resident being sent to the ER for sutures.	F 0689	regarding risk management completion, interviewing staff/obtaining witness statement, and interviewing resident when applicable regarding cognition. In specific to this incident agency staff was reeducated on thorough investigation, however, per risk management completion it appears incident review was conducted accordingly. Director of Nursing does review and sign each risk management. If concerns are identified Director of Nursing does a one on one with reeducation to correlating staff member. Yes, all audits observed will included Hoyer transfers guided per resident's individual plan of care. Yes, all falls are investigated to ensure thoroughness including resident/staff interviews as applicable. Director of Nursing reviews with clinical staff. Every fall is reviewed and will continue to be reviewed indefinitely. Yes, it is the facility's utmost opinion, a thorough investigation was concluded on 04/14/2025 following the fall of resident #25. The initial interview of the incident was concluded immediately per agency nurse at time of fall. Subsequent communication was completed, post ED return, per unit manager 04/14/2025. The new IPRO fall tracking tool was initiated 07/08/2025. The IPRO tracking tool has been utilized for all falls in the month of July 2025. This new process will continue indefinitely. Yes, all staff (nurses and CNA's) have been educated on the proper transferring techniques, via hoyer lift, post survey initiation and the AOC date, conducted per managerial nursing staff beginning 07/02/2025 through survey completion. Yes, all nurses have been re-educated on thorough fall investigation completion to include interviewing residents	

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F 0689	Continued From page 5 The DON confirmed the aides involved in the incident for Resident #19 on 06/06/25 were a hospice aide and a facility aide who was no longer employed with the facility. Review of the facility policy titled Activities of Daily Living dated September 2018 revealed staff should follow necessary precautions to ensure the safety of the residents during activities of daily living (ADLs). 2. Review of the medical record for Resident #25 revealed an admission date of 04/05/22 with diagnoses including type two diabetes mellitus, acquired absence of left leg below knee, acquired absence of right leg below knee, and chronic respiratory failure with hypoxia. Review of the progress note for Resident #25 dated 04/12/25 timed at 2:00 A.M. revealed the resident was on the floor laying on his right side between the window wall area and the bed. The bed was locked, and the side rails were up. Resident #25 complained of lower back pain and requested to go to the emergency room. Review of the fall report dated 04/12/25 at 2:00 A.M. revealed the resident was laying on the floor. Resident stated his arm was tired, so he let go of the side rail and then fell to the floor. Further review of the fall report revealed the event was not witnessed and resident did not go to	F 0689	and staff (as applicable) after the survey start and prior to the AOC date. This guidance was transcribed per Director of Nursing and expressed to staff per nurse managers. The agency nurse was provided appropriate policy and procedure guidelines for incident/progress note completion on 04/14/2025 directly via the agency portal.	

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F 0689	Continued From page 6 the hospital. Review of the care plan for Resident #25 updated 04/12/25 revealed the resident had an actual fall with minor injury. Interventions included the following: educate resident on safety techniques with positioning and the use of assist bars, and encourage rest breaks when tired. Review of the MDS assessment for Resident #25 dated 05/06/25 revealed the resident was cognitively intact and required substantial assistance with bed mobility. Interview on 07/01/25 at 9:00 A.M. with Resident #25 confirmed he had fallen from his bed in April 2025. Resident #25 confirmed he was not interviewed about the incident, and when CNA #255 came into his room to change him, she shoved him over to the right side of the bed and he fell off the edge of the bed and onto the floor. Interview on 07/07/25 at 10:08 A.M. with Licensed Practical Nurse (LPN) Unit Manager #204 confirmed she documented Resident #25's fall on 04/12/25 in the progress notes, because the agency nurse who was working at the time of the fall didn't document anything about the fall. LPN #204 confirmed the facility did not interview Resident #25 about how the fall occurred.	F 0689		

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F 0689	Continued From page 7 Interview on 07/07/25 at 11:38 A.M. with CNA #255 confirmed on 04/12/25 at approximately 2:00 A.M. she went into Resident #25's room to perform peri-care after trying to get another staff member to assist. CNA #255 confirmed she was not able to get another staff member to assist with Resident #25's peri-care, so she went into his room alone. Interview confirmed she rolled Resident #25 onto his right side, away from her, and the resident rolled out of bed onto the floor. CNA #255 confirmed the fall report was not accurate, and the fall was her fault because she rolled the resident away from her. CNA #25 confirmed the nurse didn't assess the resident or interview him. Interview on 07/07/25 at 2:25 P.M. with the Director of Nursing (DON) confirmed on 04/12/25 Resident #25 fell out of bed during routine care. The DON confirmed the fall investigation report dated 04/12/25 was not complete, and the resident was not interviewed after the fall. Review of the facility policy titled Managing Falls and Fall Risk undated revealed the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling. This deficiency represents noncompliance investigated under Complaint Number OH00166581 and Complaint Number	F 0689		

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F 0689	Continued From page 8 OH00164646.	F 0689		