STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365275	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Vista Nursing & Rehab by McAre Health	1216 5th Ave Youngstown, OH 44504

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** 39973 Based on interview, record review, review of a self-reported incident (SRI), and review of the facility policy revealed the facility did not timely report an allegation of misappropriation to the state agency. This affected one resident (#88) out of one resident reviewed for misappropriation. The facility census was 87. Findings include: Review of the closed medical record for Resident #88 revealed an admitted [DATE]. Resident #88 was discharged to the assisted living on 04/04/24. Diagnoses included hypotension, cerebral palsy, anxiety disorder, and chronic pain. Review of the witness statement dated 03/29/24 and completed by Resident #88 revealed she had an envelope of four hundred dollars that was missing from her purse in her drawer. The witness statement stated that she checked the money at least two times daily and more if needed. She had signed and dated the witness statement for 03/29/24. Review of the witness statement dated 03/29/24 at 6:30 P.M. and completed by Licensed Practical Nurse (LPN) #552 revealed LPN #552 was getting ready to go into another room when Resident #88 had asked her how she goes about reporting a robbery. The statement revealed she had asked Resident #88 what happened, and Resident #88 stated she had four hundred dollars in an envelope in her pocketbook, and it was gone. The statement revealed staff assisted Resident #88 to look through everything in her room, and nothing was found. The statement revealed management, including the Director of Nursing (DON) and Administrator, were notified. (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of SRI tracking number #245887, date of discovery as 04/02/24 at 3:21 P.M., revealed the facility filed an SRI for misappropriation (three days after the incident). The SRI revealed Resident #88 had first reported the money missing on 03/29/24 to staff and then on 04/01/24 she believed her money was stolen. Resident #88 stated she counted her money every morning and evening; therefore, she knew her money went missing on Friday, 03/29/24. Resident #88's son was contacted and verified she had money as she had wanted him to come pick it up to pay her bills. The camera was reviewed and noted three staff entered her room throughout the day (03/29/24). Laundry Aide #554 entered her room to deliver her laundry and detergent (Resident #88 was in her room at the time she had entered). State tested Nurse Aide (STNA) #555 entered her room; she stated she had completed a head count of the residents as the alarm had gone off. Maintenance Assistant #553 and he could not remember when interviewed why he had entered her room as he entered rooms for various reasons fixing things. The police were notified and came to the facility to initiate an investigation. Interview on 04/11/24 at 10:41 A.M. with Resident #88 revealed she had four hundred dollars (all in 20-dollar bills) in an envelope that she kept in a pink polka dot wallet that she kept inside a large brown purse. She kept her purse in the cabinet in her room and counted her money at least two times a day. Her son was coming to pick up the money to pay some of her bills outside in the community. She left her room on 03/29/24 and when she returned, she went to count her money inside her purse and found that the envelope with the money was gone. The purse had been in the cabinet and appeared as when she had last left it. She immediately reported to LPN #552 that her money was gone. She felt it had been stolen right from the beginning as she felt one of the other residents had taken it, but the facility stated no residents entered her room as they watched the camera. At first the facility stated they would investigate, but after they were unable to solve it, they contacted the police upon her request who came in and she filed a report with them. The case was still under investigation. Interview on 04/11/24 at 3:45 P.M. with LPN #552 revealed on 03/29/24 Resident #88 was upset stating she was missing four hundred dollars. They searched her room and were unable to locate the missing money. Management was notified. Interview on 04/16/24 at 8:56 A.M. with the Administrator and Director of Nursing (DON) verified on 03/29/24 at 6:30 P.M. per the witness statement of LPN #552, Resident #88 asked how she went about reporting a robbery as she was missing four hundred dollars. Resident #88 filled out a witness statement stating she was missing four hundred dollars from her purse in her drawer. They verified an SRI was not reported to the state agency until 04/02/24 at 3:21 P.M. which was not within 24-hours of the allegation. Review of the facility policy labeled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, dated October 2023 revealed misappropriation was the deliberate misplacement, exploitation or wrongful temporary or permanent use of residents belongs and money without the resident's consent. The policy revealed all other allegations involving neglect, exploitation, mistreatment, misappropriation of resident property and injuries of unknown source would be reported to the Ohio Department of Health immediately but in no event later than 24 hours for the time the incident/allegation was made. This deficiency was an incidental finding identified during the complaint investigation.

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, interview and facility policy review the facility failed to ensure Resident #87, who required staff assistance for activities of daily living (ADL) care, received adequate and timely incontinence care. Actual Harm occurred on 04/10/24 when Resident #87, who was totally dependent on staff for bed mobility and toileting went from 04/10/24 at approximately 6:00 A.M. to 11:52 A.M. (almost six hours) before being provided incontinence care. Resident #87 was observed to be saturated in urine resulting in a red, bleeding, open area to her right thigh that was approximately the size of a dime. Resident #87 revealed her skin was raw, hurt, and burned from the lack of timely incontinence care. She also was observed to have her incontinence brief fastened rather than being left open as ordered by the physician. This affected one resident (#87) of three residents reviewed for incontinence care. The facility identified 49 residents (#1, #2, #5, #8, #9, #10, #12, #13, #14, #15, #16, #17, #22, #25, #26, #30, #31, #33, #34, #35, #36, #38, #39, #40, #42, #43, #44, #46, #48, #49, #51, #52, #53, #57, #62, #63, #64, #66, #67, #69, #71, #74, #75, #76, #78, #83, #84, #85, and #87) who were identified to be incontinent of bowel and/or bladder. The facility census was 87. Findings include: Review of the medical record for Resident #87 revealed an admitted [DATE] with diagnoses including atrophy (muscle wasting), urinary tract infection, morbid obesity, adult failure to thrive, and needing assistance with personal care. Review of the care plan dated 02/21/22 revealed Resident #87 had an ADL self-care performance deficit related to activities intolerance, and impaired balance. Interventions included extensive assistance with two staff for toileting, mechanical lift for transfers to move between surfaces, and skin inspection with care. Review of the care plan dated 02/21/22 revealed Resident #87 had bladder incontinence related to impaired mobility. Interventions included disposable briefs and change as needed, clean peri-area with each incontinence episode, check as required for incontinence, and apply barrier cream to protect skin. Review of the care plan dated 02/09/24 revealed Resident #87 had skin alteration (right medial thigh) related to brief use. Interventions included inspecting skin during routine care, leaving brief open to air when in bed, and treatments as ordered. Review of the care plan dated 02/14/24 revealed Resident #87 can be resistant to care as she declined to get out of bed unless her sister was present to take her for a smoke, refused medications and skin checks. Interventions included if resident resisted ADL care, reassure the resident, leave and return five to ten minutes later and try again. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Review of the Braden Scale for Predicting Pressure Ulcer Risk dated 03/01/24 revealed Resident #87 was at moderate risk for developing pressure ulcers as she was slightly limited with her sensory perception, was very moist, chairfast, very limited in mobility, and she had a problem with friction and shear. Review of the readmission Bladder and Bowel Assessment completed by Registered Nurse (RN)/ Wound Nurse #550 dated 03/03/24 revealed Resident #87 was incontinent of bowel and urine. Review of the Medicare Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #87 had intact cognition. She was totally dependent on staff to roll left and right, with toileting, and transfers. She was always incontinent of bowel and bladder. She was at risk for pressure ulcers but had no unhealed pressure ulcers. Review of the nursing note dated 03/28/24 at 7:31 P.M. completed by RN/ Wound Nurse #550 revealed Resident #87's skin was assessed, and her right inner thigh was intact with no open wounds or discoloration. The note revealed to continue her treatment as preventative. Resident #87 was alert and oriented and updated on the status. Review of the April 2024 Physician Orders revealed Resident #87 had an order dated 12/07/23 to cleanse buttocks/ coccyx after each incontinence episode and apply thick layer of zinc cream every shift, an order dated 02/08/24 to apply zinc to her right medial thigh twice a day and with periods of incontinence every shift, and an order dated 02/08/24 to leave her incontinence brief open when in bed every shift. Interview and observation on 04/10/24 at 11:04 A.M. with Resident #87 revealed she was in bed under a sheet and blanket. She revealed she was last changed (provided incontinence care) on night shift, 04/10/24 at approximately 6:00 A.M. The resident stated no staff had been in to check and/or change her since. During the interview, the resident voiced concerns her incontinence care was not completed in a timely manner as it had been over five hours since the last time she was changed, and stated this happened often. The resident shared she had an open area on her bottom because they (staff) did not change her in a timely manner. She stated, it gets raw and hurts . burns. The resident stated some staff applied cream when they changed her, but some staff did not. Observation on 04/10/24 at 11:52 A.M. revealed State tested Nurse Aide (STNA) #551 entered Resident #87's room to provide her morning care, including incontinence care. The STNA revealed she began her shift at 7:00 A.M., and stated this was the first time she was able to get to change Resident #87. She revealed she started at the one end of her assignment and worked her way down the hall. She stated Resident #87 was one of the last residents she had to complete morning care for. The STNA verified it had been almost six hours since Resident #87 was changed. The STNA provided morning care including incontinence care, and the resident's incontinence brief was observed to be fastened, not opened as ordered by the physician. Resident #87's incontinence brief was saturated in urine, and STNA #551 verified it appeared Resident #87 had urinated multiple times in the brief as she stated, yeah probably by the time I got to her. She also verified on the resident's right thigh she had an open area that was approximately the size of a dime that was red and bleeding. STNA #551 provided incontinence care, applied peri guard protective barrier cream and antifungal powder. The STNA verified she was not using zinc as she was not aware the nurse was to apply zinc after each incontinence episode per the physician's order. She stated she had always just put the barrier cream on the resident. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/10/24 at 2:38 P.M. with the Administrator verified residents should be provided incontinence care every two hours and/or as needed, and Resident #87's orders to keep her incontinence brief open in bed and zinc to be applied after incontinence episodes should have been completed as ordered. Review of the progress notes from 01/01/24 through 04/10/24 revealed Resident #87 occasionally refused showers, medication, and lab work; however, there was no documented evidence Resident #87 refused incontinence care. Observation on 04/11/24 at 2:37 P.M. with RN/ Wound Nurse #550 revealed the last time (date not provided) she evaluated Resident #87, her skin was intact, including her right inner thigh, and she had not heard it had re-opened. She stated this area had been an issue before, and as preventative measure, staff were to leave the resident's brief open (unfastened), and the nurse was to apply zinc after each incontinent episode. She verified Resident #87 had a new open area to her right inner thigh that measured 2.4 centimeters (cm) in length by 0.6 cm in width, with a depth of 0.1 cm. She revealed she felt the area was an abrasion caused by the friction of her incontinence brief, especially if the brief was fastened. Interview on 04/11/24 at 3:30 P.M. with the Administrator revealed the facility did not have a policy specifically for incontinence care, instead they followed the ADL policy. On 04/16/24 at 11:45 A.M. the Administrator and Director of Nursing provided a witness statement dated 04/10/24 at 8:30 A.M. completed by STNA #573 stating she went into Resident #87's room to give her breakfast tray at 8:30 A.M., and asked Resident #87 if she needed to be changed but the resident stated she did not. (This information was provided seven days after the incident was brought to the attention of the Administrator (on 04/10/24 at 2:38 P.M.)). Interview on 04/16/24 at 12:38 P.M. with STNA #573 revealed she had started working at the facility on 04/05/24 and was still on orientation the date of incident on 04/10/24. She stated she was assigned a different section on the unit than Resident #87 resided; therefore, she was not assigned to provide direct care to Resident #87. She stated, on 04/10/24 at 8:30 A.M. she assisted in passing breakfast trays and stated she always asked every resident that she passed a tray to if they needed changed before providing them their tray. She stated she did ask Resident #87, and she stated she did not need to be changed. She stated she did not see Resident #87 anymore that day, including asking her again if she needed changed. Review of the facility policy titled Activities of Daily Living (ADL), Supporting, dated August 2021, revealed residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADL. The policy revealed appropriate care and services would be provided for residents who were unable to carry out ADL independently including incontinence care. The policy revealed care and services would be provided in accordance with their plan of care. This deficiency represents non-compliance investigated under Master Complaint Number OH00152380.