

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365760	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER Vista Center of Boardman		STREET ADDRESS, CITY, STATE, ZIP CODE 830 Boardman Canfield Rd Boardman, OH 44512	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure Resident #8 received timely incontinence care and failed to ensure Residents #8, #22, #46 and #47 received staff assistance for showering. This affected four residents (#8, #22, #46, and #47) of five residents reviewed for assistance with Activities of Daily Living (ADL) needs. The facility census was 43.</p> <p>Findings include:</p> <p>1. Review of Resident #8's medical record revealed an admitted [DATE]. Diagnoses included epilepsy, muscle weakness, abnormal posture, hemiplegia, hemiparesis right dominant side, aphasia, gastrostomy status, and pseudobulbar affect.</p> <p>Review of Resident #8's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. Resident #8 was dependent on staff for all Activities of Daily Living (ADLs) including eating, oral hygiene, toileting hygiene, showers, dressing, personal hygiene, incontinence care and bed mobility.</p> <p>Review of Resident #8's care plan dated [DATE] revealed the resident was incontinent of bowel and bladder. Goals and interventions included the resident would remain clean and odor free. Staff to administer treatments per physician orders, assist with incontinence care every two hours and as needed, apply house barrier cream as needed, monitor for signs and symptoms of urinary tract infections, monitor for skin impairments, and provide peri care as needed.</p> <p>Review of Resident #8's shower schedule revealed they were to receive showers every Monday, Wednesday and Friday.</p> <p>Review of Resident #8's shower sheets from [DATE] to [DATE] revealed the resident only received six out of the 30 scheduled showers.</p> <p>Observation on [DATE] at 2:33 P.M. of incontinence care for Resident #8 by Certified Nursing Assistant (CNA) #803 and CNA #804 revealed the resident was in Enhanced Barrier Precautions and required staff who were performing hands-on care to wear a gown and gloves, signage was outside of the door on the wall, isolation bins were inside the resident 's room with proper Personal Protective Equipment (PPE) in them. CNA #803 and CNA #804 did not put on proper PPE to perform incontinence care. Resident #8 was incontinent through brief onto incontinence pad under him and had a strong odor of urine.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 2:49 P.M. with CNA #803 and CNA #804 revealed they confirmed Resident #8 had not received incontinence care since 11:00 A.M. and was dependent on staff and should be completed every two hours and as needed. CNA #803 and CNA #804 confirmed Resident #8 had not received incontinence care in three and a half hours. CNA #803 confirmed Resident #8 had soaked through his brief onto the incontinence pad and had a strong odor of urine. CNA #803 and CNA #804 confirmed Resident #8 was in Enhance Barrier Precautions (EBP) with proper signage outside of room on the wall next to the door and Personal Protective Equipment (PPE) in bins in the resident room. CNA #803 and CNA #804 confirmed they should have been wearing gowns and gloves for incontinence care. CNA #804 confirmed that after she wiped Resident #8 she place the dirty wipes on the fitted sheet instead of putting them in the trash. CNA #803 and CNA #804 confirmed they did not change the fitted sheet on Resident #8 ' s bed after placing dirty wipes on them.</p> <p>2. Review of Resident #22's medical record revealed an admitted [DATE]. Diagnosis included acute kidney failure, difficulty in walking, need for assistance with personal care, cognitive communication deficit, type II diabetes, heart failure, hypertension, and artificial left hip.</p> <p>Review of Resident #22's MDS assessment dated [DATE] revealed the resident had impaired cognition but was able to make his needs known. They required setup or clean up assistance with eating, supervision or touching assistance with oral hygiene, upper body dressing, and bed mobility and finally they were dependent on staff for transfers, lower body dressing, toileting hygiene, personal hygiene and showers.</p> <p>Review of Resident #22's care plan dated [DATE] revealed the resident required assistance with ADLs related to weakness, difficulty in walking and cognitive deficit. Goals and interventions included the resident would continue to participate in ADLs as able and have no decline in ADLs through the review date. Staff were to monitor for decline and report to clinical staff as needed, staff to adjust care as needed to meet the resident's needs, staff to encourage residents to participate in ADLs during care, staff were to assist with daily hygiene and were to assist with showering the resident per facility policy.</p> <p>Review of Resident #22's shower schedule revealed they were to receive a shower every Tuesday, Thursday and Saturday.</p> <p>This deficiency represents non-compliance under Complaint Number OH00164239.</p> <p>Review of Resident #22's shower sheets form [DATE] to [DATE] revealed the resident only received one shower in February, eight showers in March, seven showers in April and one shower in May.</p> <p>3. Review of Resident #46's medical record revealed and admitted [DATE] and a discharge date of [DATE]. Diagnosis included cerebral infarction, acute respiratory failure with hypoxia, muscle wasting and atrophy, difficulty in walking, hypertension, anxiety and mood disorder, congenital tuberculosis, hemolytic anemia, urinary retention, opioid abuse, rhabdomyolysis, and history of falls.</p> <p>Review of Resident #46's discharge MDS assessment dated [DATE] revealed the resident had intact cognition. They required setup or clean up assistance for eating, and oral hygiene. They required supervision or touching assistance for toileting hygiene, upper body dressing, personal hygiene, and bed mobility. Finally, they required partial to moderate assistance for showers, transfers and lower body dressing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #46's shower schedule revealed they were supposed to receive a shower every Tuesday, Thursday, and Saturday.</p> <p>Review of Resident #46's shower sheets from [DATE] to [DATE] revealed the resident only received two out of 17 scheduled showers on [DATE] and on ,d+[DATE].25.</p> <p>4. Review of Resident #47's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Resident #47 expired in the facility. Diagnosis included heart failure, cognitive communication deficit, muscle weakness and wasting, need for assistance with personal care, contracture of left and right knee, anxiety, major depressive disorder, history of falling, restless leg syndrome, hypertension and history of pulmonary embolism.</p> <p>Review of Resident #47's quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. They required supervision or touching assistance for eating, partial to moderate assistance for oral hygiene and personal hygiene, substantial to maximal assistance for upper body dressing and bed mobility and finally, the resident was dependent on staff for toileting hygiene, lower body dressing and showers.</p> <p>Review of Resident #47's shower scheduled revealed the resident was to receive showers every Tuesday, Thursday and Saturday.</p> <p>Review of Resident #47's shower sheets dated from [DATE] to [DATE] revealed the resident only received four showers out of 17 scheduled showers.</p> <p>Interview on [DATE] at 10:15 A.M. with Certified Nursing Assistant (CNA) #805 revealed they confirmed they completed their assigned showers gut there were times when they did not get done.</p> <p>Interview on [DATE] at 10:20 A.M. with Licensed Practical Nurse (LPN) #801 the CNAs complete their showers but there are times when the residents complain they are not getting them.</p> <p>Interview on [DATE] at 10:25 A.M. with Registered Nurse (RN) #802 revealed CNAs do not always get to all the showers scheduled on their shift. RN #802 stated it depends on how their day is going but they try hard.</p> <p>Interview on [DATE] at 2:49 P.M. with CNA #803 and CNA #804 revealed they confirmed Resident #8 had not received incontinence care since 11:00 A.M. and was dependent on staff and should be completed every two hours and as needed. CNA #803 and CNA #804 confirmed Resident #8 had not received incontinence care in three and a half hours. CNA #803 confirmed Resident #8 had soaked through his brief onto the incontinence pad and had a strong odor of urine. Additionally, CNA #803 and CNA #804 stated they only complete their assigned showers if they had the time too.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 4:10 P.M. with the Administrator, the DON, and the Interim DON revealed they reviewed and confirmed for Resident #46 she admitted on [DATE] and did not receive their first shower until [DATE] and was supposed to receive at least three a week on Tuesday, Thursday and Saturdays. The Administrator, the DON, and the Interim DON all confirmed Resident #46 only received two showers out of 17 scheduled showers on [DATE] and [DATE]. The Administrator, the DON, and the Interim DON confirmed Resident #47 was to receive three showers a week on Tuesday, Thursday and Saturday. They confirmed Resident #47 only received four showers out of the 17 scheduled showers with no additional documentation provided. The Administrator, DON and Interim DON verified for Residents #8 they only received six out of thirty scheduled showers, and for Resident #22 they only received one shower in February, eight showers in March, and only seven showers in April.</p> <p>Interview on [DATE] at 12:18 P.M. with LPN #809 revealed showers are not always completed as scheduled. LPN #809 stated some residents and families have complained to them regarding not getting showers were scheduled.</p> <p>Interview on [DATE] at 1:45 P.M. with Resident #22 revealed they do not always receive showers as scheduled and had to remind staff they wanted a shower.</p> <p>Interview on [DATE] at 2:15 P.M. with LPN #808 revealed Resident #46 complained to them she was not getting her showers and wanted one.</p> <p>Review of the undated facility policy titled, Bathing, Showering, revealed the purpose was to establish frequency of bathing by resident choice. The procedure included Residents were to be interviewed during the admission process regarding the frequency they want to bathe/shower. If the resident is unable to relay this information, attempts are to be made to obtain this from the responsible party or person that would know the resident. The frequency of the bath/shower is reviewed at least quarterly during the care planning conference with the resident. Changes were to be implemented if indicated by the resident's choice. This policy was reviewed will all staff during the employee orientation and periodically thereafter as well the policy is reviewed with the resident during the admission process and quarterly thereafter.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</p> <p>Based on interview, observation, record review and facility policy review, the facility failed to ensure effective infection control techniques were practiced during incontinence care. This affected one resident (Resident #8) out of five residents reviewed for infection control. The facility census was 43.</p> <p>Findings include:</p> <p>Review of Resident #8's medical record revealed an admitted [DATE]. Diagnoses included epilepsy, muscle weakness, abnormal posture, hemiplegia, hemiparesis right dominant side, aphasia, gastrostomy status, and pseudobulbar affect.</p> <p>Review of Resident #8's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. Resident #8 was dependent on staff for all Activities of Daily Living (ADLs) including eating, oral hygiene, toileting hygiene, showers, dressing, personal hygiene, incontinence care and bed mobility.</p> <p>Review of Resident #8's care plan dated 03/04/25 revealed the resident was incontinent of bowel and bladder. Goals and interventions included the resident would remain clean and odor free. Staff to administer treatments per physician orders, assist with incontinence care every two hours and as needed, apply house barrier cream as needed, monitor for signs and symptoms of urinary tract infections, monitor for skin impairments, and provide peri care as needed.</p> <p>Review of Resident #8's physician orders dated May 2025 revealed Resident #8 was ordered to be in Enhanced Barrier Precautions every shift due to wounds and presence of peg tube for enteral feedings.</p> <p>Observation on 05/01/25 at 2:33 P.M. of incontinence care for Resident #8 by CNA #803 and CNA #804 revealed the resident was in EBP and required staff who were performing hands-on care to wear a gown and gloves, signage was outside of the door on the wall, isolation bins were inside the resident's room with proper PPE in them. CNA #803 and CNA #804 did not put on proper PPE to perform incontinence care.</p> <p>Interview on 05/01/25 at 2:49 P.M. with Certified Nursing Assistant (CNA) #803 and CNA #804 revealed CNA #803 and CNA #804 confirmed Resident #8 was in Enhance Barrier Precautions (EBP) with proper signage outside of room on the wall next to the door and Personal Protective Equipment (PPE) in bins in the resident's room. CNA #803 and CNA #804 confirmed they should have been wearing gowns and gloves for incontinence care and they were not.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Enhanced Barrier Precautions, dated July 2022, revealed the purpose was to reduce the transmission of multidrug-resistant organisms (MDROs) by when high contact resident care activities for residents with known colonized or infected with MDRO as well as those at increased risk to acquire and MDRO. Under the procedure section it stated Residents with the following triggers will receive EBP and indicates it should be followed for any resident in the facility with 1. An open wound requiring a dressing change, 2. Has an indwelling catheter for the duration of their stay and 3. Is colonized with MDROs and contact precautions do not apply. EBP requires the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.</p> <p>This deficiency represents non compliance under Complaint Number OH00164239.</p>		