STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365760	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Center of Boardman	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy, the facility failed to ensure all allegations of abuse were reported to the state agency as required. This affected four residents (#9, #10, #16, and #51) out of five residents reviewed for abuse. The facility census was 47.Findings include:1. Review of the medical record for Resident #9 revealed an admission date of 10/09/24. Diagnoses included acute kidney failure, cognitive communication deficit, type two diabetes, adult failure to thrive, and depression.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/18/25 revealed the resident had impaired cognition. The resident required setup or clean up assistance for eating, supervision for oral hygiene, dressing, and bed mobility, and were dependent on staff for showers, toileting hygiene, and personal hygiene.Review of the nurse progress notes dated from 06/05/25 to 07/02/25 revealed on 06/05/25 the resident was ordered Silvadene cream (a cream used to treat burns) one percent twice a day times 10 days for burns to face with no other documentation regarding how they received the burns.2. Review of Resident #10's medical record revealed an admission date of 04/16/25. Diagnoses included dementia, benign prostatic hyperplasia, and acute gastritis without bleeding.Review of Resident #10's admission MDS 3.0 assessment dated [DATE] revealed the resident had slight impairment in cognition, they were independent for eating, oral hygiene, and bed mobility, they required supervision for showers, dressing and personal hygiene and set up assistance with toileting hygiene.Review of Resident #10's care plan dated 05/14/25 revealed an alteration in cognitive function related to dementia.Review of Resident #10's progress notes dated 06/05/25 at 12:09 P.M. authored by Licensed Practical Nurse (LPN) #840 revealed the resident became agitated when Resident #9 cut in line for coffee. Resident #10 then took the cup of coffee he had in his hands and threw it in Resident #9's face. Review of the facility Self-Reported Incidents (SRI) revealed there was no SRI submitted by the facility on 06/05/25 regarding an incident allegation of resident-to-resident abuse involving Resident #9 and Resident #10.An interview on 07/01/25 at 12:42 P.M. with the Administrator and the DON revealed Resident #10 threw coffee at Resident #9 which hit him in the face and caused burns which were treated with Silvadene one percent cream twice a day for 10 days. They both confirmed they did not report this incident of resident-to-resident abuse to the state agency and they did not do a thorough investigation as to why this incident occurred.An interview on 07/01/25 at 2:52 P.M. with both of Resident #9 ' s responsible parties revealed they were not notified of Resident #10 throwing coffee in Resident #9 ' s face and that he was treated for burns.Interview on 07/01/25 at 3:53 P.M. with Certified Nursing Assistant (CNA) #850 revealed Resident #9 had coffee thrown in his face by Resident #10 and sustained burns to his face and was treated. CNA #850 described the burns as red marks without blisters.Interview on 07/02/25 at 5:55 P.M. with LPN #840 revealed Resident #9 had burns to his face related to Resident #10 throwing coffee at him. The burns did not blister and were not open. The areas were red. LPN #840 notified the physician who implemented an order for Silvadene cream to be applied twice a day for 10 days to affected areas. LPN #840 stated she reported the incident to the DON when it happened.3. Review of Resident #16's medical record revealed an admission date of 10/15/24. Diagnoses included transient cerebral ischemic attack, vascular dementia, adult failure to thrive, type two diabetes, and major depressive disorder.Review of Resident #16's quarterly MDS 3. 0 assessment dated [DATE] revealed the resident had severely impaired cognition they were independent with eating, oral hygiene, dressing, personal hygiene, and bed mobility, and they required set up help only with toileting.Review of Resident #16's care plan dated 02/24/25 revealed no concerns regarding resident behavior.4. Review of Resident #51's medical record revealed an admission date of 05/01/25 and a discharge date of 06/24/25. Diagnoses included elevated sodium levels, muscle weakness, unsteadiness on feet, need for assistance with personal care, hypertension, atrial fibrillation, and dementia.Review of Resident #51's discharge MDS 3.0 assessment revealed the resident had intact cognition. They required setup assistance with eating, oral hygiene, were independent with bed mobility and required partial to supervision assistance with toileting, showers, dressing, and personal hygiene.Review of Resident #51's care plan revealed no concerns related to aggressive behaviors.Review of Resident #51's progress notes dated 06/13/25 at 1:30 P.M. revealed the resident was observed by staff to be standing above his roommate Resident #16 verbally abusing and swearing at him. When asked what happened Resident #51 stated his roommate would not stop talking. Nursing staff placed the resident in a different room. Additional review of Resident #51's progress notes revealed on 06/17/25 at 3:30 A.M. a guest at the facility (Resident #50's

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy, the facility failed to ensure all allegations of abuse were thoroughly investigated. This affected four residents (#9, #10, #16, and #51) out of five residents reviewed for abuse. The facility census was 47.Findings include:1. Review of the medical record for Resident #9 revealed an admission date of 10/09/24. Diagnoses included acute kidney failure, cognitive communication deficit, type two diabetes, adult failure to thrive, and depression.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/18/25 revealed the resident had impaired cognition. The resident required setup or clean up assistance for eating, supervision for oral hygiene, dressing, and bed mobility, and were dependent on staff for showers, toileting hygiene, and personal hygiene.Review of the nurse progress notes dated from 06/05/25 to 07/02/25 revealed on 06/05/25 the resident was ordered Silvadene cream (a cream used to treat burns) one percent twice a day times 10 days for burns to face with no other documentation regarding how they received the burns.2. Review of Resident #10's medical record revealed an admission date of 04/16/25. Diagnoses included dementia, benign prostatic hyperplasia, and acute gastritis without bleeding.Review of Resident #10's admission MDS 3.0 assessment dated [DATE] revealed the resident had slight impairment in cognition, they were independent for eating, oral hygiene, and bed mobility, they required supervision for showers, dressing and personal hygiene and set up assistance with toileting hygiene. Review of Resident #10's care plan dated 05/14/25 revealed an alteration in cognitive function related to dementia.Review of Resident #10's progress notes dated 06/05/25 at 12:09 P.M. authored by Licensed Practical Nurse (LPN) #840 revealed the resident became agitated when Resident #9 cut in line for coffee. Resident #10 then took the cup of coffee he had in his hands and threw it in Resident #9's face.Review of the facility Self-Reported Incidents (SRI) revealed there was no SRI submitted by the facility on 06/05/25 regarding an incident of resident-to-resident abuse involving Resident #9 and Resident #10.An interview on 07/01/25 at 12:42 P.M. with the Administrator and the DON revealed Resident #10 threw coffee at Resident #9 which hit him in the face and caused burns which were treated with Silvadene one percent cream twice a day for 10 days. They both confirmed they did not report this incident of resident-to-resident abuse to the state agency and they did not do a thorough investigation as to why this incident occurred.An interview on 07/01/25 at 2:52 P.M. with both of Resident #9 ' s responsible parties revealed they were not notified of Resident #10 throwing coffee in Resident #9 ' s face and that he was treated for burns.Interview on 07/01/25 at 3:53 P.M. with Certified Nursing Assistant (CNA) #850 revealed Resident #9 had coffee thrown in his face by Resident #10 and sustained burns to his face and was treated. CNA #850 described the burns as red marks without blisters.Interview on 07/02/25 at 5:55 P.M. with LPN #840 revealed Resident #9 had burns to his face related to Resident #10 throwing coffee at him. The burns did not blister and were not open. The areas were red. LPN #840 notified the physician who implemented an order for Silvadene cream to be applied twice a day for 10 days to affected areas. LPN #840 stated she reported the incident to the DON when it happened.3. Review of Resident #16's medical record revealed an admission date of 10/15/24. Diagnoses included transient cerebral ischemic attack, vascular dementia, adult failure to thrive, type two diabetes, and major depressive disorder.Review of Resident #16's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition they were independent with eating, oral hygiene, dressing, personal hygiene, and bed mobility, and they required set up help only with toileting. Review of Resident #16's care plan dated 02/24/25 revealed no concerns regarding resident behavior.4. Review of Resident #51's medical record revealed an admission date of 05/01/25 and a discharge date of 06/24/25. Diagnoses included elevated sodium levels, muscle weakness, unsteadiness on feet, need for assistance with personal care, hypertension, atrial fibrillation, and dementia.Review of Resident #51's discharge MDS 3.0 assessment revealed the resident had intact cognition. They required setup assistance with eating, oral hygiene, were independent with bed mobility and required partial to supervision assistance with toileting, showers, dressing, and personal hygiene.Review of Resident #51's care plan revealed no concerns related to aggressive behaviors.Review of Resident #51's progress notes dated 06/13/25 at 1:30 P. M. revealed the resident was observed by staff to be standing above his roommate Resident #16 verbally abusing and swearing at him. When asked what happened Resident #51 stated his roommate would not stop talking. Nursing staff placed the resident in a different room. Additional review of Resident #51's progress notes revealed on 06/17/25 at 3:30 A.M. a guest at the facility (Resident #50's family) reported to them

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record reviews and interviews, the facility failed to ensure there was a Registered Nurse (RN) present in the facility eight consecutive hours seven days a week. This had potential to affect all residents. The facility census was 47.Findings include:Record review was conducted of the nursing services staffing schedule and completion of the staffing tool for the date range of 06/22/25 to 06/27/25 with Human Resources Manager (HRM) #807. The facility met or exceeded the minimum staffing requirement of 2.5 hours of direct care per resident per day, however, on 06/25/25 an RN was not on staff for eight consecutive hours that day. Interview on 07/02/24 at 3:30 P.M. with HRM #807 revealed the facility was staffed based on acuity and census numbers. There should be one nurse on each unit and one aide. The DON was full-time, and they were required to have an RN eight hours a day seven days a week. HRM #807 confirmed on 06/25/25 they did not have required RN coverage for this day.This deficiency represents non-compliance identified during investigation of Complaint Number OH00167011.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests on the secured unit A. This affected 19 Residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, and #19) out of 47 residents observed for physical environment. The facility census was 47. Findings include:Observations made on 07/01/25 at 9:30 A.M. and 07/02/25 at approximately 11:45 A.M. of rooms occupied by Residents' #12, #13, #16, #17 and #18 revealed there were bed bugs present in each room on the secured A unit.An interview on 07/01/25 at 3:33 P.M. with Licensed Practical Nurse (LPN) #811 revealed there were bed bugs found on the secured unit A approximately one week ago and the facility did not treat them until today. The staff caught a few and put them into a container and gave them to the maintenance director and the Director of Nursing (DON).An interview on 07/01/25 at 3:38 P.M. with LPN #830 revealed they caught three bed bugs the morning of 07/01/25 in the room of Resident #12 and #13 and bagged up all the resident clothing per policy in yellow bags and notified laundry. They then sprayed down the residents' bed and showered the resident.An interview on 07/01/25 at 3:53 P.M. with Certified Nursing Assistant (CNA) #850 revealed there were bed bugs on the secured A unit in the rooms of Resident #12, #13, #16, #17 and #18. CNA #850 stated the bed bugs were found on residents in these rooms and one was found on a staff member. A interview on 07/02/25 at 10:00 A.M. with Maintenance Director (MD) #815 revealed Orkin pest control found and treated for bed bugs in rooms of Resident #12, #13, #16, #17 and #18. MD #815 stated there were additional bed bugs found in the dining room/lounge area on the secured A unit and MD #815 had to throw away four chairs, and the mattress and chair in the room of Resident #12 and #13. MD #815 stated Orkin did a chemical treatment only today and would be back on 07/16/25 for a second treatment of affected rooms.Review of invoices dated 07/02/25 at 12:11 P.M. from Orkin exterminating revealed they inspected the rooms of Resident #12, #13, #16, #17 and #18 and the dining/lounge area on the secured A unit and found bed bugs present. They completed a chemical treatment only to all affected areas and would be returning on 07/16/25 to complete a second treatment.An interview on 07/02/25 at 2:15 P.M. with the Pest Exterminator (PE) #900 via phone revealed they confirmed no heat treatment was completed at the facility for bed bugs, just a chemical treatment and a heat treatment was the treatment needed to stop the bed bug activity in the facility. PE #900 stated they would be returning on 07/16/25 to complete a second treatment.This deficiency represent non-compliance identified during investigation of Complaint Number OH00167011 and OH00166114.