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	08/20/2025

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 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. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, interview and policy review, the facility failed to provide interventions to prevent the development of an unstageable pressure ulcer, failed to timely and accurately document the initial assessment and weekly comprehensive assessments of the pressure ulcer, failed to timely coordinate ancillary wound care services to mitigate complications related to pressure ulcers, and failed to follow proper infection control procedures during wound care. This affected one (Resident #41) of two residents reviewed for pressure ulcers. The facility census was 51. Findings include:Review of the medical record for Resident #41 revealed an admission date of 03/09/25 and a re-entry date of 05/28/25. Resident #41 had diagnoses including unspecified dislocation of the right hip, adult failure to thrive, presence of bilateral artificial knee joints, Parkinson's disease, tachycardia, primary hypertension, osteoarthritis, and need for assistance with personal care. Review of the weekly skin assessment completed on 05/28/25 revealed Resident #41 had some bruising on the right arm and right leg but otherwise had intact skin. Review of the care plan dated 05/28/25 revealed Resident #41 was at risk for impaired skin integrity and pressure ulcers related to impaired mobility and incontinence. The care plan listed three interventions: apply barrier cream after each incontinent episode as needed (PRN), elevate heels off mattress, and encourage fluids. The care plan did not include turning or repositioning to redistribute weight off Resident #41's pressure points while in bed. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 06/10/25 revealed Resident #41 had intact cognition and was dependent on staff for toileting hygiene, bathing, transfers in and out of bed and required substantial assistance to roll left and right in bed. Further review of the MDS revealed Resident #41 had occasional bladder incontinence and was at risk for pressure injury but had no pressure injuries, ulcers, lesions, rashes, surgical wounds, burns, skin tears, or moisture associated skin damage (MASD) at the time of the assessment. Review of the weekly skin assessment completed on 06/11/25 revealed Resident #41 had redness noted to the coccyx and a barrier cream was applied. There were no progress notes or additional assessment details noted in the medical record related to the size of the reddened area or whether the area was blanchable. No additional interventions were added to the care plan. Review of the orders revealed a physician order dated 06/12/25 (discontinued on 07/10/25) to cleanse the coccyx of Resident #41 with normal saline solution (NSS) and apply calcium alginate and a foam dressing daily and PRN. Review of the Treatment Administration Record (TAR) from June 2025 revealed documentation of wound care treatments daily from 06/12/25 through 06/30/25, except for 06/18/25, when Resident #41 was in the emergency room (ER). Review of the progress notes from 06/12/25 revealed there were no notes related to the new wound care orders for Resident #41's coccyx. Review of all assessments for Resident #41 revealed there were no assessments related to the wound care orders that were initiated on 06/12/25. The care plan revealed no new interventions were added to the skin integrity care plan, and no care plan focus was added related to actual skin impairment until 08/14/25. Review of the assessment titled Skin Grid Pressure 3.0 - V 2 completed on 06/19/25 revealed Resident #41 had a Stage two (II) pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) to the sacrum that measured 1.5 centimeters (cm) by 1.2 cm by 0.2 cm with an onset date documented as 06/19/25 related to a leave of absence (LOA) or ER visit. The wound tissue was documented as 100 percent (%) pink with moderate serosanguinous exudate (drainage) and no signs of infection. The peri wound (tissue surrounding the wound) was intact, fragile, and moist. The medical record revealed no comprehensive wound assessment or tracking between 06/19/25 and 07/03/25, including the wound size (length, width, depth), wound stage, amount, color, consistency, and odor of wound exudate, wound bed tissue, wound edges and surrounding skin, signs of infection or inflammation, presence of pain, and status (healing, stalled, stable, declined). However, there was a weekly skin assessment completed on 06/25/25 which revealed Resident #41 had an open lesion. The note further revealed Open areas to coccyx. The assessment did not indicate there had been a previously identified pressure area and there was no comprehensive wound assessment documented. Review of the physician orders revealed orders dated 06/26/25 for Resident #41 to have house liquid protein supplements, 30 milliliters (ml), twice daily by mouth for 60 days (the pressure ulcer was first identified on 06/12/25). Review of the Skin Grid Pressure 3.0 - V 2 assessment completed on 07/03/25 revealed Resident #41 had an unstageable pressure area (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) to the sacrum which measured 2.0 cm by 1.5

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, medical record review, review of facility policy, and review of the Centers for Disease Control and Prevention (CDC) on-line guidance for use of personal protective equipment (PPE) for care of persons with COVID-19 (the novel coronavirus, also known as severe acute respiratory syndrome two or SARS-CoV-2), the facility failed to ensure the appropriate type of transmission-based precautions for Resident #41was identifiable to staff and visitors, failed to ensure proper infection control procedures were maintained during wound care for Resident #41, and failed to ensure appropriate precautions were maintained when providing care for Resident #35. This affected two residents (Residents #35 and #41) but had the potential to affect eight residents who were identified by the facility as having wounds (Residents #21, #28, #33, #41, #42, #44, #45, and #50) and six residents who were in droplet isolation (Residents #19, #21, #26, #27, #35, and #44). The facility census was 51. Findings include: 1. Review of the medical record for Resident #41 revealed an admission date of 03/09/25 and a re-entry date of 05/28/25. Diagnoses included unspecified dislocation of the right hip, adult failure to thrive, presence of bilateral artificial knee joints, Parkinson's Disease, tachycardia, primary hypertension, osteoarthritis, and need for assistance with personal care. Review of the care plan dated 05/28/25 revealed Resident #41 was at risk for infection related to a chronic wound. Interventions included maintaining enhanced barrier precautions (EBP) as indicated. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 06/10/25 revealed Resident #41 had intact cognition and was dependent for toileting hygiene, bathing, transfers in and out of bed and required substantial assistance to roll left and right in bed. Further review of the MDS revealed Resident #41 had occasional bladder incontinence and was at risk for pressure injury but had no pressure injuries, ulcers, lesions, rashes, surgical wounds, burns, skin tears, or moisture associated skin damage (MASD) at the time of the assessment. Review of the physician orders revealed an order dated 07/29/25 for Resident #41 to be in contact isolation with no further description or instructions. Further review of the order revealed contact isolation was discontinued on 08/11/25. Review of the physician orders also revealed a treatment order dated 08/01/25 which was for Resident #41 to have the sacral wound cleaned with NSS or wound cleanser, pat dry, lightly pack with calcium alginate rope, and cover with a silicone super absorbent dressing every day shift for wound management. Observation on 08/13/25 at 2:35 P.M. revealed one cart containing PPE, one covered bin for trash, and one covered bin for linen in the hall outside the door to the room of Resident #41. Further observation revealed there were two signs hanging on Resident #41's door, one that specified Resident #41 was in EBP and one identifying Resident #41 as requiring contact isolation. Interview on 08/13/25 at 2:35 P.M. with Certified Nurse Aide (CNA) #354 revealed the belief Resident #41 was in EBP for a large wound and no knowledge as to why the contact isolation sign was on the door. Interview on 08/13/25 with Licensed Practical Nurse (LPN) #350 revealed a statement that contact isolation and EBP were the same thing and the contact isolation sign was probably there to remind staff which PPE to wear when providing care to Resident #41 because she had a large wound. Observation on 08/13/25 from 3:18 P.M. to 3:35 P.M. of wound care for Resident #41 performed by Licensed Practical Nurse (LPN) #350 revealed a gown, mask, face shield, and two pairs of gloves were donned prior to entering the room of Resident #41. As the PPE was being applied, LPN #350 stated double-gloving would be used to minimize movement around the room during wound care between steps of the procedure so that one pair could be removed once the old dressing was off and the other pair of gloves could be used to continue wound care without stepping away to perform hand washing between glove changes. Before wound care commenced, two normal saline bullets, dry gauze, a package containing calcium alginate rope, and a package containing a silicone absorbent border dressing were laid on the bedside stand without the bedside stand being cleaned or a barrier set-up for the dressing supplies. The packaging for the calcium alginate rope and silicone border dressing were opened slightly (the seal was opened one edge of each package, but the other three edges remained intact, and the packages remained closed over top of the dressing supplies). LPN #350 was observed removing the old dressing, which was undated and soiled in urine and stool, wrapped the old dressing in the top layer of gloves, removed the top layer of gloves, and discarded in the trash can at the bedside. While wearing the bottom layer of gloves, LPN #350 squirted two 15 milliliter (ml) saline bullets onto the wound bed, wiped around the wound bed with dry gauze, used the gloved hands to manipulate the package containing the calcium alginate rope, used the same gloved hands to press the calcium alginate rope into the wound bed and undermined edges, then grabbed the package containing the silicone border