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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Center of Boardman	830 Boardman Canfield Rd Boardman, OH 44512

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, policy review and review of the microessentiallab.com website, the facility failed to have unexpired test strips to test for proper sanitization levels at the three-sink manual dish washing area. This had the potential to affect 45 residents receiving food from the facility kitchen. There was one (Resident #19) identified by the facility as receiving nothing by mouth. The facility census was 46.Findings include:An observation during the initial tour of the kitchen on 02/17/26 at 8:15 A.M. revealed Hydrion test strips (test strips used to test for proper sanitization levels of chemicals to ensure efficacy) with an expiration date of 11/01/25 at the three-sink manual dish washing area. Dietary [NAME] #513 verified the expiration date of 11/01/25 on the Hydrion test strips at the time of the observation.A review of the undated facility policy titled; Manual Ware Washing revealed manually washed pots, pans and cooking utensils shall be adequately sanitized using a three-part process including wash, rinse, and sanitize. The policy further revealed sanitizer concentration should be checked and recorded prior to each use. Proper test strips should be readily available.A review of the undated facility policy titled; 3 Compartment Sink Sanitizer Strength Record revealed sanitizer strength shall be monitored and recorded to ensure that all manually washed utensils, pots and pans are properly sanitized. The policy further revealed sanitizer strength in the third tank of the three-compartment sink shall be monitored prior to each use and recorded by the food and nutrition services staff.A review of the website microessentiallab.com revealed the color chart on the Hydrion strip package is marked with the expiration and lot number for that specific roll. The pH paper will remain accurate until the expiration date listed.

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and facility policy review, the facility failed to maintain a sanitary garbage storage area. This had the potential to affect all residents. The facility census was 46.Findings include:An observation of the outside dumpster area on 02/17/26 at 8:30 A.M. revealed approximately six pairs of used vinyl medical gloves scattered on the ground around the dumpster. The lid to the dumpster was open. The side slide door was open. Dietary [NAME] #513 verified the findings at the time of the observation.A review of the facility policy titled; Garbage Removal and Dumpster, dated 12/21/21, revealed garbage can attract pests and contaminate food, equipment and utensils if not handled correctly. The policy further revealed the garbage dumpster must have a tight-fitting lid and or slide door and must be covered at all times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review, observation, interview, review of the Centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to maintain a clean and sanitary laundry environment to prevent the spread of germs, failed to ensure staff performed hand hygiene to prevent cross contamination of germs during medication administration for Resident #33 and Resident #21, failed to properly clean the glucometer after use to obtain Resident #39's blood sugar, failed to contain Resident #60's contaminated linen and personal protective equipment (PPE) appropriately and failed to provide Resident #1 with a sanitary area to eat his meal. This affected three (Residents #21, #33, #39) out of six residents observed for medication administration, one (Resident #39) out of two residents observed for blood glucose monitoring, one (Resident #1) out of one resident observed for dining, one (Resident #60) of one resident reviewed for isolation precautions and had the potential to affect all the residents in the facility. The facility census was 46.Findings include:1. A review of Resident #21's clinical record revealed an admission date of 07/24/25 with diagnoses including chronic obstructive pulmonary disease (COPD), morbid obesity, obstructive sleep apnea (OSA), shortness of breath (SOB), kidney disease, polyneuropathy, high blood pressure, depression, hypothyroidism, heart failure, acute and chronic respiratory failure with hypoxia dependence on a ventilator status, and periapical abscess without sinus (a pocket of infection around the root of a tooth or surrounding tissue).A review of Resident #21's Medication Administration Record (MAR) dated 02/01/26 to 02/28/26 indicated to administer Lorazepam 2 milligrams (mg) (antianxiety) orally at 4:00 P.M.An observation on 02/17/26 at 3:36 P.M. revealed Registered Nurse (RN) #537 administered Lorazepam 2 mg orally to Resident #21. RN #537 obtained the Lorazepam from the medication cart and walked in Resident #21's room and administered the Lorazepam to Resident #21. RN #537 exited the room and did not perform hand hygiene and proceeded to obtain medications for Resident #33.A review of Resident #33's clinical record revealed an admission date of 09/26/25 with diagnoses including dysphagia (trouble swallowing), encephalopathy, vitamin D deficiency, hypo-osmolality and hyponatremia, demyelinating disease of the central nervous system, high blood pressure and cholesterol, epilepsy with convulsions, bipolar disorder and depression, COPD, Crohn's disease, anemia, and malnutrition.A review of Resident #33's MAR dated 02/01/26 to 02/28/26 indicated to administer Lurasidone hydrochloride 20 mg (antipsychotic) orally three times a day.An observation of RN #537 on 02/17/26 at 3:41 P.M. revealed RN #537 obtained one medication from the medication cart and administered the Lurasidone hydrochloride 20 mg to Resident #33 orally. RN #537 was then asked to perform hand hygiene before continuing to administer medications to other residents.An interview with RN #537 on 02/17/26 at 3:50 P.M. verified she had failed to perform hand hygiene before and after administering medications to Resident #21 and Resident #33.The facility policy titled: Hand Washing, dated 09/2025, indicated to perform hand hygiene at the following times: When reporting to work and before going home Before eating and drinking Before and after using the bathroom After sneezing. coughing or blowing your nose After touching your hair, face etc. After smoking a cigarette Before and after each resident contact After touching a resident or handling his/her belongings Whenever hands are obviously soiled After contact with any body fluids After handling any contaminated items 2. A review of Resident #60's clinical record revealed an admission date of 05/16/25 and readmission date of 02/02/26 with diagnoses including diabetes mellitus, hypo-osmolality, hyponatremia, hypokalemia, alcoholic polyneuropathy, viral hepatitis, arthritis, high blood pressure and cholesterol, Parkinsonism, gastroesophageal reflux disease (GERD), and generalized anxiety.An observation on 02/17/26 at 3:00 P.M. revealed outside of Resident #60's bedroom there was a sign indicating Resident #60 should have contact isolation precautions implemented to prevent the spread of infection. There were two large boxes lined with yellow biohazard bags located outside Resident #60's room containing discarded PPE in one box and soiled linen in another box. An interview with RN #537 at the time of the observation verified the boxes were (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	located outside of Resident #60's room. RN #537 was unsure where the boxes were supposed to be located. RN #537 stated Resident #60 had a Methicillin Resistant Staphylococcus Aureus (MRSA) infection of his right foot and contact isolation precautions were implemented to prevent the spread of the infection.An interview with RN #542 on 02/17/26 at 3:05 P.M. revealed the two boxes of PPE and linens outside of Resident #60's room should be placed inside his room per the facility policy.A review of the Centers for Disease Control guidelines titled Management of Multidrug-Resistant Organisms in Healthcare Settings, dated 2006, indicated contact isolation precautions should be implemented for patients with MRSA infections. Discarded used PPE and soiled linens should be stored inside of the patient's room in a plastic bag labeled bio-hazardous material. Staff should remove their PPE prior to exiting the patient's room and place the discarded PPE in the waste contained with a plastic bag labeled bio-hazardous material. 3. A review of Resident #39's clinical record revealed an admission date of 01/30/26 with diagnoses including heart failure, respiratory failure, diabetes mellitus, kidney failure, soft tissue disorder, polyneuropathy, high blood pressure, peptic ulcer, gout, testicular, bilateral foot and right knee pain, and alcohol abuse.A review of Resident #39's MAR dated 02/01/26 to 02/28/26 indicated to administer Lispro insulin 100 units/milliliter 3 units subcutaneously before meals related to diagnosis of diabetes mellitus.An observation of Licensed Practical Nurse (LPN) #524 on 02/18/26 at 7:44 A.M. revealed LPN #524 obtained Resident #39's blood glucose level using a glucometer. LPN #524 obtained Resident #39's blood sugar and administered the above listed Lispro insulin to Resident #39. LPN #524 proceeded to clean the glucometer with a sanitized disposable wipe. An inspection of disposable sanitizing wipes container revealed the sanitizing solution did not contain bleach.An interview on 02/18/26 at 7:50 A.M. with LPN #524 verified the above findings and stated she was aware she should have used a sanitizing wipe solution that contained bleach and but there were no sanitizing wipes with bleach available to use to clean the glucometer in her medication cart.A review of the facility's policy titled Glucometer Cleaning Solution (undated) revealed to use a disposable sanitizing wipe with bleach to clean the glucometer after each use. Allow wet time per manufacturer's guidelines.4. A review of Resident #1's clinical record revealed an admission date of 10/16/23 with diagnoses including respiratory failure, COPD, emphysema, dysphagia, encephalopathy, atrial fibrillation (heart arrhythmia), epilepsy, OSA, dementia, depression, kidney failure and suicidal ideations.An observation of Resident #1 on 02/18/25 at 8:00 A.M. revealed Resident #1 was seated on the side of his bed eating his breakfast. Resident #1's breakfast meal tray was located on the over-the-bed table with a urinal filled two thirds of the way full of dark yellow urine sitting on the table beside his meal tray. An interview with Resident #1 at the time of the observation revealed he had used the urinal prior to the staff serving him his breakfast meal. Resident #1 stated the staff delivered his meal tray and placed it beside the urinal filled urine. An interview at 8:05 A.M. on 02/18/26 with Certified Nursing Assistant (CNA) #571 agreed she had delivered Resident #1's meal tray and should have moved Resident #1's urinal prior to serving him his breakfast meal and not placed the meal tray beside his urinal with urinal two thirds full of urine.5. An observation on 02/19/26 at 8:41 A.M. with Laundry Assistant (LA) #523 revealed there were three rooms in the basement of the facility used for washing, drying and folding the laundry. The following observations were verified by LA #524 at the time of the observations:- In the room containing the two dryers miscellaneous unfolded lost and found resident's clothing were piled on two shelves of a wheeled cart and on two plastic milk cartons with a thick layer of lint/dust covering the clothing. There were miscellaneous unfolded blankets piled on a chair with dirt and debris on the blankets. A five-shelf metal cart contained various unfolded clothing items piled on each shelf with some of the clothing dangling over the edge on to the floor. A wheeled cart with a shelf on the bottom and rod across the top to hang clothing contained clean resident's clothing. There were various clothing items on the bottom shelf of the cart hanging over the edge and touching the floor. There was lint piled up on the floor along the edges of the room. The tile floor was stained with dried liquid and built-up brown grit/grime.- In the room containing the two washing machines there were multiple pillows stacked (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	waist high on the floor against the wall. There was a large box of new linens with some soiled blankets on top of the boxes sitting on the floor. There were bed linens in plastic wrap and a resident's belt sitting on top of the red hazardous waste container. There was a blanket on the floor in front of the washing machine to catch the water dripping from a hose in need of repair on the front of the washing machine. There were three black non-skid mats in front of the washing machines with thick packed debris in the creases of the non-skin mats. There were several missing/loose tiles in front and behind the washing machines. There was a thick layer of dried cleaning products and peeling rusty brow colored substance behind the washing machines. A utility sink contained bed, bath and personal resident's linen soiled with feces placed in a bucket located inside the sink. The floors were covered with grit/grime and dirt.An interview with LA #524 on 02/19/26 at 9:00 A.M. stated she was the only staff member working in the laundry room and did not have time to clean the laundry rooms as needed. LA #524 agreed that the floors in the laundry areas had not been thoroughly cleaned routinely and the two rooms were dirty and unorganized. LA #524 stated the facility needed to hire another laundry person to assist her with maintaining a sanitary washing area.A review of the CDC guidelines for Infection Control Assessment of Laundry Facility Preparedness indicated implementing the following guidelines for prevention of spread of infection:-Staff Training and Certification: Ensure that laundry facility supervisors and frontline personnel have completed training in managing healthcare laundry and are certified in laundry management. -PPE Availability: Make sure that PPE such as gowns, gloves, and face masks is readily available for personnel working on the soiled side. - Cleanliness Standards: Verify that surfaces throughout the facility are constructed from materials that withstand wet cleaning and high humidity, and that handwashing sinks are functional with soap and drying equipment. - Soiled Textiles Handling: Ensure that soiled textiles are contained in leak-resistant bags and that Universal/Standard Precautions are followed when sorting soiled textiles. - Air Quality and Ventilation: Check that there is proper ventilation in the facility, either through negative airflow to the soil side or positive airflow from the clean side to the soil side. - Equipment Maintenance: Conduct regular maintenance and calibration of laundry equipment according to manufacturer recommendations. - Infection Control Practices: Follow best practices for handling dirty laundry, including proper procedures and temperatures for laundering.

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F 0677 Level of Harm - Minimal harm or potential for 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** Based on record review, observation, interview and facility policy review, the facility failed to ensure proper grooming for Resident #53 related to removal of facial hair. This affected one (Resident #53) of three residents reviewed for activities of daily living. The facility census was 46.Findings include:Review of Resident #53's medical record revealed an admission date of 07/20/10 and pertinent diagnoses of Multiple Sclerosis, bipolar disorder, dysphagia, muscle wasting and atrophy, vascular dementia, lack of coordination, hypertensive retinopathy, corneal deformity and congenital malformation of the eye.Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Basic Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. Resident #53 was dependent on staff for all activities of daily living (ADL) and mobility and required a Hoyer (mechanical) lift for all transfers.Review of the care plan dated 12/05/25 stated Resident #53 was totally dependent with ADL and all care, and interventions included staff would assist with daily hygiene.On 02/17/26 at 1:22 P.M. an observation of Resident #53 revealed an excessive amount of facial hair on her chin.On 02/18/26 at 9:32 A.M. an additional observation of Resident #53 revealed an excessive amount of facial hair on her chin which was confirmed by Certified Nursing Assistant (CNA) #535.On 02/18/26 at 9:32 A.M. an interview with CNA #535 revealed Resident #53's chin hair was often long as staff could not keep up with how quickly it grew. CNA #535 further stated staff shaved the resident twice per week during her showers, but they did not shave her more often than that.On 02/19/26 at 9:33 AM an interview with CNA #548 confirmed excessive chin hair on Resident #53 and stated she never shaved this resident and had no knowledge of how often the resident was supposed to be shaved.Review of the facility's policy titled Resident Care, revised 06/2018, revealed typical personal hygiene for a resident included removal of women's facial hair.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to change nasal cannula tubing (a plastic tube with two prongs that goes into the nose to deliver oxygen) weekly for appropriate respiratory infection control. This affected one (Resident #1) of one resident reviewed for respiratory care and had the potential to affect 10 additional residents (2, #4, #13, #19, #21, #22, #23, #24, #30, and #38) identified by the facility as receiving oxygen therapy. The facility census was 46.Findings include:Review of the medical record for Resident #1 revealed the date of admission to be 10/16/23. Significant diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and acute respiratory failure. Significant orders included change oxygen tubing/cannula/mask every week, every night shift, on every Saturday, dated 11/01/25, and oxygen at four liters per minute via nasal cannula as needed (PRN) to keep oxygen saturation above 90%, dated 10/30/25.Review of the annual Minimum Date Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status to have a score of 15 out of 15, indicating resident #1 was cognitively intact. The MDS also revealed oxygen therapy was in use.Review of the care plan dated 02/05/26 revealed Resident #1 had an alteration in respiratory function and required oxygen use. An intervention included administering oxygen as ordered.An observation on 02/17/26 at 11:26 A.M. revealed Resident #1 seated in his wheelchair with oxygen being administered via nasal cannula at four liters per minute. The nasal cannula was dated 01/25/26. Registered Nurse (RN) #537 verified the date on the nasal cannula at the time of the observation. RN #537 stated oxygen tubing was to be changed weekly.Review of the undated facility policy titled; Nasal Cannula revealed the nasal cannula is recommended to be changed weekly and as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure medications were not left at the bedside for one resident (Resident #33) out of seven residents observed for medication administration. The facility census was 46.Findings include:Review of the medical records for Resident #33 revealed the initial date of admission of 06/03/24 and a readmission date of 09/26/25 with a diagnosis of chronic obstructive pulmonary disease (COPD). Significant orders included Advair diskus (a prescription dry powder inhaler to manage COPD) inhalation aerosol powder 250/50, inhale one puff two times a day for COPD. There were no orders noted in the medical record for Resident #33 to have the medication left at the bedside, nor were there any orders within the medical record for Resident #33 to self-administer the Advair. There were also no orders in the medical record for Resident #33 to have an Advair aerosol inhaler.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating Resident #33 had moderate cognitive impairment.Review of the assessments within the medical record revealed no medication self-administration assessment (an assessment done to ensure a resident can self-administer medications safely and effectively) for Resident #33.Review of the care plan dated 02/07/26 revealed no medication self-administration interventions.An observation on 02/17/26 at 9:51 A.M. revealed an Advair diskus powder inhaler and an Advair aerosol inhaler on the over-the-bed table of Resident #33. Assistant Director of Nursing (ADON) #507 verified the two inhalers on the over-the-bed table of Resident #33 at the time of the observation. ADON #507 stated the inhalers should not have been left at the bedside of Resident #33 and further stated Resident #33 did not have an order to self-administer medications.Review of the facility policy titled; Medication Storage/Storage of Medication, dated 2007, revealed medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The policy further revealed medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access.Review of the facility policy titled; Medication Administration General Guidelines, dated 01/25, revealed medications are to be administered at the time they are prepared. The policy further revealed residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care centers interdisciplinary team in in accordance with procedures for self-administration of medication and state regulations.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure Resident #11's call light activation button was within reach to ensure it could be utilized. This affected one (Resident #11) of 46 residents screened for call light placement. The facility census was 46.Findings include:Review of the medical record for Resident #11revealed the date of admission as 04/22/23. Significant diagnoses included dementia, unspecified severity without behavioral disturbance, need for assistance with personal care, and muscle weakness. There were no significant orders regarding the call light placement.Review of the care plan dated 12/16/25 revealed Resident #11 was at risk for falls. Interventions included commonly used articles within easy reach: water, call light, remote control, telephone etc.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of nine indicating Resident #11 had moderate cognitive impairment. Resident #11 was dependent for toileting and showers.An observation on 02/17/26 at 9:56 A.M. revealed Resident #11 lying in bed. The call light activation button was located on top of a mini refrigerator to the left side of the bed underneath several papers on top of the mini refrigerator. The mini refrigerator was approximately three feet from the bedside of Resident #11. Certified Nurse Aide (CNA) #562 verified the placement of the call light activation button at the time of the observation.Review of the facility policy titled; Call Light Answering, dated 12/24, revealed the purpose of the policy is to assure the facility is adequately equipped with a call light at each residence bedside, toilet, and bathing facility to allow residents to call for assistance. The policy further revealed all staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. Finally, the policy revealed staff will ensure the call light is within reach of each resident and secured as needed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed ensure Resident #9's room was in good repair. This affected one (Resident #9) 46 during the initial screening and initial tour. The facility census was 46.Findings include:Review of the medical record for Resident #9 revealed the date of admission as 02/06/25. Significant diagnoses included type one diabetes mellitus, immunodeficiency due to conditions classified elsewhere and difficulty walking. There were no significant orders regarding noncompliance for room disrepair.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #9 was cognitively intact.Review of the care plan dated 12/05/26 revealed no indications that Resident #9 refused housekeeping and maintenance services.An observation on 02/18/26 at 8:35 A.M. revealed Resident #9's room was in general disrepair. The wall between the sink and bathroom had a large deep gouge just above the baseboard approximately three feet long. The floor along the baseboard had a visible buildup of dirt and debris. There was visible buildup of dirt and debris behind the entrance door in the corner. The baseboard behind bed A was missing. Resident #9 was noted to be in bed B of the room. The baseboard at the entrance door was noted to be coming away from the wall. Maintenance Director (MD) #532 verified the findings at the time of the observation. MD #532 stated he was not sure when the gouge happened in the wall between the bathroom and the sink. MD #532 also stated he was not sure when the baseboard went missing behind bed A of the room.