STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365823	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Center at the Ridge	3379 Main Street Mineral Ridge, OH 44440

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, and review of the facility policy, the facility failed to maintain fall prevention interventions as ordered by the physician for Resident #112 to prevent further falls. This affected one resident (#112) of three residents reviewed for accidents. The facility census was 125. Findings include: Record review for Resident #112 revealed an admitted [DATE]. Diagnoses included encephalopathy, unspecified dementia with other behavioral disturbances, spinal stenosis, muscle weakness, difficulty in walking, unspecified psychosis, and Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #112 was rarely or never understood. Resident #112 had no impairment to the upper or lower extremities and used no mobility devices. Resident #112 required setup or cleanup assistance with meals, substantial/max assistance for toileting, and partial/moderate assistance for transfers. Resident #112 had no falls since admission. Record review of the fall history for Resident #112 revealed Resident #112 had falls on 05/20/24, 05/30/24, and 06/13/24. Review of the fall risk evaluation dated 05/17/24 at 1:18 P.M. completed by Registered Nurse (RN) #254 revealed a score of 19 (high risk). Review of the progress notes dated 05/20/24 at 8:09 P.M. for Resident #112 completed by RN #266 revealed at 7:15 P.M. staff found Resident #112 on his right side on the floor of the right side of his bed and reported to this nurse. Cleansed four centimeters (cm) by four cm abrasion on the right elbow and applied a bordered gauze dressing. Resident was to walk with a walker, but the resident's walker was nowhere to be found. Every shift, staff was to ensure Resident #112 had his walker within reach. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 05/30/24 at 6:55 A.M. completed by Registered Nurse (RN) #271 revealed Resident #112 was found on the floor in his room by the state tested nursing assistant (STNA). This nurse was notified and went to assess the resident. Resident #112 was on the floor supine next to his bed. There was a very noticeable bump to the right side of his forehead. He was conscious and responded to us accordingly. Pain and discomfort were displayed by moaning and facial grimacing. A new intervention was to keep a light on in his room at night. Review of the progress note dated 06/13/24 at 4:52 P.M. completed by Licensed Practical Nurse (LPN) #237 revealed Resident #112 was found on floor in the dining room lying on his back. Staff reported that Resident #112 was sitting in a stationary chair prior to the fall. The intervention included staff will redirect Resident #112 back to the wheelchair until he builds up his strength. Review of the care plan for Resident #112 dated 03/01/21 and updated on 05/20/24, 05/30/24, and 06/13/24 revealed Resident #112 was at risk for falls and potential injury related to dementia, incontinence, impaired physical mobility, and osteoarthritis in the right hip. Added interventions included: Attempt to keep the resident's walker within reach of the resident, dated 05/20/24. Keep the light on at night, dated 05/30/24. Redirect from the stationary chair to the wheelchair until the resident regains his strength, dated 06/13/24. Review of the physician orders for Resident #112 revealed on 06/12/24 Resident #112 received an order to ensure the resident's walker is within the resident's reach. On 06/13/24 Resident #112 received an order to redirect the resident back to the wheelchair until he builds back up strength, and transfer with two assists with a wheeled walker. Observation on 07/02/24 at 10:41 A.M. revealed Resident #112 was sitting in a stationary chair in the lounge/dining area working on workboard's. Resident #112 rambled incoherently when spoken to. Observation revealed there was no wheelchair or walker present. Medication Aid #255 also observed Resident #112 and confirmed he had recent falls. Medication Aid #255 walked away and did not offer a wheelchair or walker to Resident #112. Interview on 07/02/24 at 11:10 A.M. with RN #266 revealed Resident #112 was confused but did follow directions. Resident #112 had recent falls, interventions were in place, and Resident #112 was supposed to use a walker for ambulation. Observation on 07/02/24 at 11:45 A.M. revealed Resident #112 was now sitting in a stationary chair located in the television (TV) lounge. STNA #297 verified Resident #112 walked independently from the lounge/dining area to the TV lounge. STNA #297 confirmed Resident #112 did not use his walker when he walked to the TV lounge and confirmed she did not know where it was. STNA #297 revealed, [Resident #112] should have his walker and we did not get it for him, but we should have. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/02/24 at 12:47 P.M. with the Director of Nursing (DON) confirmed Resident #112 had three recent falls. The DON revealed on 06/13/24, Resident #112 flipped out of his stationary chair onto the floor. The intervention on 06/13/24, after the fall, was to redirect Resident #112 from the stationary chair to a wheelchair until he regained strength. The DON revealed Resident #112 should be sitting in a wheelchair at all times unless he ambulated with staff using his walker. The DON confirmed the walker should be within Resident #112's reach per the physician orders. Observation on 07/02/24 at 1:52 P.M. with the DON, verified Resident #112 was sitting in a stationary chair in the TV lounge. Observation and interview on 07/02/24 between 1:53 P.M. and 1:58 P.M. with DON, STNAs #297 and #331 (Resident #112's assigned STNA's) revealed both STNAs #297 and #331 confirmed Resident #112 ambulated independently. Both STNAs #297 and #331 confirmed they did not know Resident #112 required two assists with ambulation and should sit in a wheelchair rather than a stationary chair. Review of the undated facility policy titled, Fall Management revealed the facility will identify each resident who is at risk for falls and will develop a plan of care and implement interventions to manage falls. This deficiency represents non-compliance investigated under Complaint Number OH00154608.