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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365823 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/28/2025 |
| NAME OF PROVIDER OR SUPPLIER Vista Center at the Ridge | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Resident #128 was provided a 30-day notice at discharge and appropriate discharge planning to secure safe discharge placement. This finding affected one (Resident #128) of three residents reviewed for discharge planning.</p> <p>Findings include:</p> <p>Review of submitted concerns to the state agency on 04/08/25 revealed the facility attempted to send Resident #128 to a group home, but the resident did not want to live in the area due to distance from friends and local stores. The facility did not offer any other places for the resident to be discharge to. Resident #128 was approached about being discharged on 04/03/25 and he reported to the facility he did not have anywhere to go. Resident #128 was discharged from the facility on 04/04/25 with no place to go other than a hotel. Resident #128 was discharged to a hotel and was not provided a 30-day notice.</p> <p>Review of Resident #128's medical record revealed the resident was admitted on [DATE] and discharged on 04/04/25 with diagnoses including morbid obesity, difficulty in walking and epilepsy.</p> <p>Review of Resident #128's Social History Evaluation dated 12/13/24 revealed the resident lived in a hotel and was not able to return due to trashing the place.</p> <p>Review of Resident #128's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.</p> <p>Review of Resident #128's Multidisciplinary Care Conference form dated 03/20/25 at 8:33 A.M. revealed the resident was present for the meeting and did not have family involvement. The resident's medications were reviewed and the resident stated he cannot go back to his prior living arrangements due to being evicted from his hotel room. The resident was homeless.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident #128's Notice of Adverse Decision form dated 04/02/25 revealed that the request for continued stay at the nursing facility cannot be approved. The dates of service from 04/02/25 to 04/03/25 had been approved but starting on 04/04/25 the stay was denied. The resident was [AGE] years old and had been in the facility since 12/13/24. The resident did not need skilled nursing daily and no longer needed therapy five days a week. The therapy notes showed the resident was able to do all his own daily needs like taking a bath, moving in bed, walking, using the restroom, eating and getting dressed. The resident did not need 24-hour care for memory impairment and the resident's needs can be managed at a lower level.</p> <p>Review of Resident #128's social service progress note dated 04/03/25 at 2:30 P.M. authored by Social Service Designee (SSD) #814 revealed the resident's last covered day was 04/03/25 and the resident stated he had been looking for housing due to being evicted from the motel he lived in for the last year. He had not been able to locate anything. SSD #814 called the Budget Inn hotel, and they had rooms available at a weekly rate of \$270.00. SSD #814 made the resident an appointment to establish a primary care provider (PCP) and the resident had an appointment on 04/24/25 at 3:00 P.M. A referral was sent to home health services, and the therapy department had provided the resident with home exercises.</p> <p>Review of Resident #128's medical record revealed no evidence Resident #128 was issued a 30-day discharge notice, evidence the facility coordinated discharge services with the Ombudsman, or assisted the resident in seeking resources to secure safe housing and alternative discharge placement other than a hotel. The medical record did not contain evidence Resident #128 was in agreement to be discharged to a hotel.</p> <p>Review of Resident #128's Resident Fund Management Service (RFMS) statement dated 04/03/25 revealed the resident withdrew \$1,190.00 (one thousand one hundred and ninety dollars) from the account prior to discharge.</p> <p>Review of Resident #128's Discharge Review dated 04/03/24 at 3:48 P.M. revealed the resident was discharged home with prescriptions.</p> <p>Review of Resident #128's progress note dated 04/04/25 at 1:15 P.M. authored by Registered Nurse (RN) #817 revealed the discharge instructions were explained and provided to the resident. Medication cards and an inhaler with instructions were provided and the resident verbalized and signed understanding. The resident was transported via a wheelchair in the facility transport van.</p> <p>Review of Resident #128's progress note authored by the Director of Nursing (DON) dated 04/05/25 at 4:41 P.M. revealed a courtesy call was made to the resident and he stated he was adjusting well and had enough food/medication to be comfortable to the next week. The resident wanted information on the group home and was inquiring if that was still an option for him. The DON documented she would inquire and follow-up with the resident on 04/06/25.</p> <p>Interview on 05/27/25 at 7:20 A.M. with Assistant DON #808 revealed Resident #128 came from a hotel and was admitted with a fungal rash. Assistant DON #808 stated the resident was cut from therapy, appealed and lost the appeal. She confirmed the resident did not want to turn over his check and pay for an additional stay at this facility and was discharged to a hotel. She stated the facility transported the resident using the facility transport bus.</p> <p>(continued on next page)</p> | | |

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| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on 05/27/25 at 7:37 A.M. with RN #810 revealed Resident #128 came from a hotel and she discharged the resident to a hotel per the resident's request.</p> <p>Interview on 05/27/25 at 9:10 A.M. with the Administrator revealed Resident #128 chose to be discharged from the facility to a hotel. The Administrator revealed the resident did not want to pay patient liability to stay in the facility and the facility closed the resident's RFMS account and gave the resident the \$1,190.00 that was in the account. The Administrator also confirmed the Ombudsman's office was not involved in the resident's discharge from the facility.</p> <p>A telephone call was placed to the hotel on 05/27/25 at 10:15 A.M. and Resident #128 was no longer living at the hotel.</p> <p>A second interview on 05/27/25 at 10:08 A.M. with the Administrator indicated Resident #128 did not want to pay the liability for the facility and chose to discharge. She stated the resident was having a hard time finding a place to go and the facility assisted the resident to find a hotel in which the resident could afford. The Administrator denied the facility had kicked the resident out at any point and that was why a 30-day discharge notice was not initiated.</p> <p>Telephone interview on 05/27/25 at 10:14 A.M. with the Ombudsman revealed their department had a history with Resident #128 and the facility did not inform them of the resident's discharge on [DATE] to a hotel.</p> <p>An interview on 05/27/25 at 12:23 P.M. with the DON indicated she attempted to call Resident #128 on 04/07/25 and the phone just rang. She stated the Administrator called the group home and gave them the resident's phone number. She was unsure of the date and time. The DON confirmed she did not document the follow up in the resident's medical record.</p> <p>A second interview on 05/27/25 at 12:27 P.M. with the Administrator confirmed she called the group home on [DATE] at 3:05 P.M. and gave them Resident #128's phone number for them to call the resident for admission.</p> <p>Review of the undated Discharge Planning and Managing Length of Stay policy revealed it was recommended that the facility's Administrator and/or Admission's Coordinator communicate to the hospital representatives the information that would be needed upon admission. This would allow the facility to provide an optimal plan of care throughout the resident's stay. A final discharge summary would be completed upon discharge that can be provided to the resident or an authorized person including a reconciliation of medications with post discharge medication orders and post discharge plan of care. The post discharge plan of care would include where the individual plans to reside, any arrangements that have been made for the residents' follow up care, and any post discharge medical and/or non-medical services. The Ombudsman must be notified in writing of all transfers and discharges.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164484.</p> | | |