

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 12/03/2025
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure Resident #143's Advance Directive (legal document outlining your future medical care in the event you cannot communicate them yourself) code status was accurate. This affected one resident (#143) of three residents reviewed for code status and had the potential to affect 52 residents (#4, #5, #8, #11, #12, #15, #16, #27, #29, #30, #32, #34, #36, #37, #46, #47, #54, #57, #63, #65, #68, #70, #73, #76, #77, #87, #89, #90, #91, #92, #96, #99, #100, #101, #103, #104, #105, #109, #110, #111, #112, #113, #114, #118, #119, #121, #122, #128, #133, #134, #138 and #163) with an Advance Directive. The facility census was 143. Findings include: Review of the medical record for Resident #143 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included diabetes, dementia, muscle weakness, depression, and breast cancer. Review of the Brief Interview for Mental Status (BIMS) evaluation dated [DATE] revealed Resident #143 was severely cognitively impaired. The Minimum Data Set (MDS) assessment was not yet due to be completed. Review of the history and physical progress note dated [DATE] and authored by Certified Nurse Practitioner (CNP) #207 revealed Resident #143 was a Full Code (all possible measures are attempted to save a patient's life during a medical emergency). Review of the multidisciplinary care conference dated [DATE] revealed Resident #143 had a code status of Do not Resuscitate: Comfort Care (a type of Do-Not-Resuscitate order indicating CPR should not be administered; DNRCC). Review of the nursing progress note dated [DATE] at 6:47 A.M. authored by Licensed Practical Nurse (LPN) #203 revealed she was called to the room around 5:25 A.M. by the Certified Nurse Aide (CNA) #210 because Resident #143 was unresponsive. Cardiopulmonary Resuscitation (CPR; an emergency procedure for someone whose breathing or heartbeat has stopped, involving chest compressions and rescue breaths to keep blood and oxygen flowing to vital organs until medical help arrives) was initiated and an emergency code, as well as 911 was called, and the residents' son/Power of Attorney (POA) were notified. When emergency services arrived, Resident's #143's heart had stopped beating. Interview on [DATE] at 10:55 A.M. with LPN #203 revealed CNA #210 told her Resident #143 was unresponsive, so she checked the resident's code status in the computer and found nothing regarding Advanced Directives. She then checked the physical chart where she saw a yellow sheet of paper in the front of the chart which was used to indicate the resident was a Full Code, at which time she began CPR and contacted emergency services. She said she did not find out until a few days after Resident #143 expired that she was a DNRCC. Interview on [DATE] at 11:26 A.M. with Resident #143 son/POA revealed Resident #143 was a DNRCC when she was admitted to the facility according to her own wishes. He confirmed the facility had called him to notify him she had an emergency code and he arrived within approximately half an hour, during which time the resident had already expired. He could not confirm if the facility told him they had initiated CPR and whether or not they honored the resident's wishes for her DNRCC. Interview on [DATE] at 1:28 P.M. with Social Service Designee (SSD) #206 revealed she held a care conference with Resident #143's son on [DATE], at which time he chose to make the residents' code status a DNRCC. She revealed at that time, the form was faxed to CNP #207 which was signed and placed in the residents' physical chart. She revealed she notified Registered Nurse (RN) #208 of the change in Resident #143's code status and asked her to update the order. SSD #206 confirmed there was no order in Resident #143's chart regarding any code status. A call was made on [DATE] at 1:35 P.M. to RN #208 and a message left to return the call. No return call was received. Interview on [DATE] at 2:18 P.M. with the Administrator confirmed Resident #143 was a DNRCC at the time she expired, and CPR should not have been initiated. She also confirmed there was no physician's order for the DNRCC. Review of the undated facility policy titled Advanced Directives revealed the facility would ensure residents' Advanced Directive wishes were honored including revising and reviewing directives as necessary. Facility staff would document the presence of an Advanced Directive, and the physician would write an appropriate order for residents choosing Advanced Directives. This deficiency represents noncompliance investigated under Complaint Numbers 2627715 and 2618634.</p>		