| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366067 | A. Building<br>B. Wing | 03/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vista Care Center of Milan | 185 S Main St<br>Milan, OH 44846 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49793<br><br>Based on record review, staff interview, and facility policy review, the facility failed to ensure staff implemented the facility abuse policy by reporting a potential incident of physical abuse, this affected one, Resident #22, of seven residents reviewed for abuse. The facility census was 84.<br><br>Findings Include:<br><br>Resident #22 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), type II diabetes mellitus, morbid obesity, Bipolar disorder, anxiety disorder, cognitive communication deficit, schizoaffective disorder and psychosis due to unknown physiological condition.<br><br>Review of the most recent quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 was severely cognitively impaired and required extensive assistance to dependence of two persons for completing her activities of daily living (ADLs).<br><br>Review of census records revealed Resident #22 was not her own responsible party but relied on her representatives to make all necessary medical and financial decisions.<br><br>Review of the care plan dated 01/09/24 revealed Resident #22 had noted behaviors such as socially inappropriate verbal outbursts, screaming out profanities, yelling at other residents, and rejection of care. The resident also will transfers herself out of bed and will roll on the floor. Resident #22's interventions included to provide a calm relaxing environment, one on one care as needed, offer to sit in the common area and to take the resident outside as weather permits or as she request, (assure proper clothing and footwear).<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of internal facility incident dated 02/14/25 revealed on 12/31/24 between 7:30 P.M. and 9:15 P.M., a formerly employed LPN, designated for charge of Unit 300 notified Certified Nursing Assistant (CNA) #108 that Resident #22, who was located in the common area celebrating the upcoming New Year, was engaging in inappropriate verbal outburst using vulgarities and disrupting the other residents in close proximity. CNA #108 applied appropriate weather wear on Resident #22 and exited the building to the landing just outside the back door for re-direction, which is listed in Resident #22's care plan as an intervention. CNA #107 who is no longer employed at the facility witnessed this type of redirection and alleged this type of re-direction was inappropriate and possible abuse but failed to immediately report this incident due to possible retaliation from the LPN, Director of Nursing (DON), and Administration. Upon finally notifying a fell ow Registered Nurse (RN) on 01/17/25, the RN immediately notified Social Service Director (SSD) #104. SSD #104 immediately referred this information to the Administrator and DON in which an immediate investigation was launched and concluded on 02/14/25 revealing unsubstantiated of abuse.<br><br>Interview on 03/11/25 at 11:00 AM with CNA #108 confirmed he was the CNA caring for Resident #22 on 12/31/24. The CNA stated between 7:30 P.M. and 9:30 P.M., the nurse on duty instructed him to place appropriate wear on Resident #22 and take the resident just outside the entrance/exit door of the unit to re-direct the resident due to loud yelling and the resident being over stimulated, due to the staff and residents being in the common activity room to celebrate the New Year. CNA #108 stated Resident #22 had no verbalization indicating she did not want to go outside. The CNA verified the resident had on a gown, socks, a jacket and was covered with two blankets as it was chilly outside but there was no snow or other inclement weather. Resident #22 was re-directed within two to three minutes and returned to the festivities in the activities room. The nurse on the hall also removed Resident #22 in the same manner later that evening for the same issue and returned to the common activity room after re-direction within two to three minutes wearing the same attire. Resident #22 remained cooperative throughout the remainder of the evening to celebrate the New Year and staff were able to paint the resident's nails. CNA #108 reveaeld the staff utilized many different diversions to re-direct Resident #27. The resident usually sits in her room on the floor on a mat and they had already attempted this. Taking the resident outside was another option for re-direction and she at times will go out and be with the smoking residents, even though the resident is a non-smoker.<br><br>Telephone interview on 03/11/25 at 11:58 A.M. with former CNA #107 revealed she was working on the 300 unit on the day shift on 12/31/24 and stayed over for overtime floating between the 200 unit and 300 unit. Resident #22 was observed yelling and screaming at around 7:30 P.M. and another CNA was instructed by the on-duty nurse to remove Resident #22 to the outside for re-direction. It was cold out and CNA #108 placed blankets on Resident #22 prior to going outside and stood outside the back door for about three minutes until the resident calmed down. The staff did this about four or five times throughout the evening. The resident calmed down each time, but CNA # 107 stated she thought it was too cold out for this to go on. CNA #107 confirmed she did not report this incident until she told a different nurse sometime in the middle of January, around the 17th of the month. CNA #107 stated she didn ' t come forward immediately due to fear the DON would terminate her employment or retaliate against her, which is why she stated she told another nurse. CNA #107 stated I think that the other nurse that I told this to on 01/17/25, immediately went to the social services person (SSD #104) and that person immediately told the Administrator and DON. CNA #107 verified there was no physical harm done to the SR when this all happened that night.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with the Director of Nursing (DON) on and 03/12/25 at 8:47 AM revealed staff utilized many different diversions to re-direct Resident #22, including sitting in her room on the floor on a mat and taking the resident outside. The DON confirmed the resident will often go outside with the smoking residents even though she is a non-smoker as she likes this.<br><br>Interview with the Administrator, Regional Quality Assurance Nurse #109, and DON on 03/12/25 at 1:48 P.M. confirmed CNA #107 did not timely report a possible incident of abuse to the facility administration. The Administrator confirmed the facility had not reported the incident to the state agency or law enforcement once the facility was made aware of the allegation as the facility viewed the incident as an unsubstantiated incident based on the staff following the care plan and there was no harm caused to Resident #22.<br><br>Review of the facility policy entitled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revealed:<br><br>A. all new hires will be trained on the facility policy on Abuse, Neglect, Exploitation of Residents and Misappropriation of Property during the orientation process prior to commencement of work.<br><br>B. Training shall include: Appropriate interventions to deal with aggression and catastrophic events.<br><br>C. How staff should report their knowledge of allegations without fear of reprisal and how employees can express their grievances. Investigation of all alleged violations are to be communicated immediately to the Administrator or designee, to which an investigation procedure will be commenced immediately.<br><br>This deficiency represents non-compliance investigated under Master Complaint Number OH00162968. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49793<br><br>Based on medical record review, resident interview, staff interview and facility policy review, the facility failed to ensure physician orders were accurately transcribed and residents received the correct medications. This affected two (#61 and #29) of seven residents reviewed for medication administration. The facility census was 84.<br><br>Findings Include:<br><br>1. Resident #61 was admitted to the facility on [DATE] with diagnoses that included Huntington's disease, dementia with behavioral disturbance and psychotic episodes, mood disturbance, anxiety disturbance, and Bipolar disorder.<br><br>Review of the most recent significant change minimum data set (MDS) 3.0 assessment dated [DATE], revealed the resident had severe cognitive impairment, delusions, and hallucinations. The resident had verbal behavioral symptoms directed towards others, behavioral symptoms not directed towards others, and rejection of care coded on the assessment.<br><br>Review of Resident #61's medical record revealed the resident was unable to be his own responsible party.<br><br>Review of Resident #61's orders revealed the resident had orders for Austedo 12 milligrams (mg) two tablets twice daily dated 06/06/24 and discontinued on 11/05/24. Austedo XR 24 hour 12 mg daily dated 01/08/25 to be administered from 01/09/25 and discontinued on 01/16/25, Austedo XR 24 hour 18 mg daily dated 01/08/25 to be administered from 01/17/24 and discontinued on 01/24/25, Austedo XR 24 hour 24 mg daily dated on 01/08/25 to be administered starting 01/25/25 and discontinued 02/01/25, and Austedo XR 24 hour 30 mg daily dated on 01/08/25 to start on 02/02/25.<br><br>Review of Resident #61's medication administration record (MAR) for December 2024, January 2025, and February 2025 revealed Resident #61 received no doses of Austedo in December 2024, and in January his orders for Austedo were initiated as ordered on 01/08/25.<br><br>Interview on 03/12/25 at 8:37 A.M. with Licensed Practical Nurse (LPN) #103 confirmed she received an order for Resident #61 on 12/26/24 for Austedo 6 mg twice daily for Huntington's disease from the physician and she transcribed the medication order into another resident's medical record in error, and did not transcribe the order for Resident #61.<br><br>Interview on 03/12/25 at 8:47 A.M. with the Director of Nursing (DON), confirmed there was a medication error related to LPN #103 transcribing a physician order for Austedo into the wrong resident's medical record. The DON stated, during a quarterly quality assurance meeting on 02/15/25 the error was discovered.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Resident #29 was admitted to the facility on [DATE] with diagnoses that include schizoaffective disorder, asthma, hypertension, and chronic obstructive pulmonary disease (COPD). Review of the most recent quarterly MDS 3.0 assessment dated [DATE] revealed Resident #29 was cognitively intact. The resident required minimal assistance to no assistance from staff with activities of daily living (ADL).<br><br>Review of the form titled Nursing Home Note completed by the practitioner dated 01/12/25 revealed the resident was seen by the practitioner for a monthly visit and multiple medical issues. Upon entering the room, found resident calm, alert, and lying in bed. The resident does not appear to be in distress or discomfort. Impression and Plan Schizoaffective disorder: the resident was following with psychiatric services. On Paliperidone (antipsychotic), Remeron (antidepressant), and Austedo (used to treat tardive dyskinesia and chorea related to Huntington's disease).<br><br>Review of progress notes dated 2/7/2025 at 12:55 P.M. revealed the resident is currently on hospice. He does not take any medications, and he had no concerns or issues with staff or activities.<br><br>Review of the medication administration record (MAR) for Resident #29 revealed the resident had an order for Austedo 6 mg twice a day for Huntington's disease dated 12/26/24 with a discontinuation date of 02/07/25.<br><br>Review of Resident #29's MARs for December 2024, January 2025 and February 2025 revealed the resident received Austedo on the evening of 12/31/24, on the morning of 01/01/25, and on the morning and evening of 01/10/25.<br><br>Interview on 03/11/25 at 10:48 A.M. with Resident #29 the Resident stated, I usually don't take my medications as I hate taking them. They are always trying to get me to take them, but I don't like them. I have never had any reactions to the medications or taking the medications. I just mainly want to be left alone. I don't really want to be here, but it is what it is. I feel safe and the staff treat me with respect and dignity, but I would rather be home.<br><br>Interview on 03/12/25 at 8:47 A.M. with the Director of Nursing (DON) confirmed Resident #29 had Austedo 6 mg twice daily transcribed into his medical record in error, and the resident received four doses of the medication but refused the rest of the doses offered by the facility staff. The DON confirmed Resident #29 frequently refuses his medications from the staff.<br><br>Review of a policy titled Medication Administration Policy and Procedures, dated 02/2017, revealed medication shall be administered in accordance with a valid physician order.<br><br>This deficiency represents non-compliance investigated under Master Complaint Number OH00162968. |