

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Vista Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Vista Drive Lisbon, OH 44432	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019</p> <p>Based on closed medical record review, policy review, and interview, the facility failed to timely address resident health concerns resulting in the resident leaving the facility against medical advice (AMA). This affected one resident (Resident #7) of three residents reviewed for medications.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, muscle wasting and atrophy, chronic congestive heart failure, anxiety disorder, post-traumatic stress disorder, and major depressive disorder. The resident left the facility, against medical advice (AMA), on 07/22/23 at 2:20 A.M.</p> <p>Review of the admission assessment, dated 07/21/23, revealed the resident was cognitively intact.</p> <p>Review of a physician order, dated 07/21/23, revealed the order for buspirone (an anti-anxiety medication) HCL, one five milligram (mg) tablet by mouth four times per day for major depressive disorder.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Vista Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Vista Drive Lisbon, OH 44432	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a nurse progress note, authored by Licensed Practical Nurse (LPN) #21, dated 07/22/23 at 2:44 A. M., revealed the resident was made aware several times at 8:00 P.M. that her medications would be delivered sometime tonight. Medications that were available to be pulled from the Emergency Kit were administered to the resident. At 12:30 A.M. the resident stated, I feel like I'm not breathing right. The resident's pulse oximetry was 96% and she received oxygen at three liters. Her lungs were clear but diminished. The resident was asked if she was feeling anxious due to this being her first night, and informed that her vital signs were within normal limits. The resident stated she wanted to go home and was going to call her husband. This nurse educated her on the need to stay and the resident agreed at that time. At 1:45 A. M. the resident asked if her medications had been delivered and the nurse informed her that they had arrived, but she had received medications from the emergency kit and the time frame for the rest had closed and she would have to wait until the morning to receive the other medication doses. The resident stated, I can't take this anymore, I'm calling my husband to come get me. The resident was unable to be educated on staying and stated, she does not want to be here and has medications at home. The resident signed the AMA form, her husband came in at 2:20 A.M. with a bag of medications and pushed the resident to the car via wheelchair. The resident stated before leaving, you know I have had a heart attack before. The nurse stated that her vital signs were within normal limits and the resident had not complained of chest pain or shortness of breath. The resident stated, yeah, I now, I was just letting you know it happened so fast the last time. The nurse asked the resident to consider staying if she had worries, but the resident refused and stated I thought I could make this work, but I just can't. The resident was given a copy of her AMA form.</p> <p>Review of the Medication Administration Record (MAR), dated July 2023, revealed the resident did not receive her scheduled dose of Buspirone HCL five milligram (mg), one tablet, at 5:00 P.M. or at 9:00 P.M. on 07/22/23.</p> <p>Interview on 06/11/24 at 1:00 P.M. with the Director of Nursing (DON) revealed Resident #7 did not receive buspirone HCL five milligram (mg), one tablet, as ordered by the physician even after it was received from the pharmacy. The DON further confirmed LPN #21 should have notified the physician of the second missed dose of the medication per facility policy.</p> <p>Interview on 06/11/24 at 1:05 P.M. with the Administrator revealed LPN #21 was an agency nurse and her (the Administrator) expectation would have been for the physician to have been notified of Resident #7's symptoms. The Administrator further stated LPN #21 should have notified herself or another manager when Resident #7 asked to leave AMA as is the facility's policy.</p> <p>Review of a policy titled, Medication Administration, dated December 2012, revealed medications are administered in accordance with written orders of the prescriber. If two consecutive medications doses of a vital medication is withheld or refused, the physician is notified.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153954.</p>		