

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 05/01/2025
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 0562</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide immediate access to any resident.</p> <p>42015</p> <p>Based on observation and interviews with family, staff, residents, and the Ombudsman, the facility failed to ensure residents and family members were able to contact facility staff members via the telephone. This had the potential to affect all residents in the facility. The facility census was 45.</p> <p>Findings include:</p> <p>Review of the two anonymous complaint intake reports reported to the state agency revealed facility staff did not answer the facility telephones.</p> <p>Attempted phone calls made by the State agency on 04/29/25 at 5:36 P.M., 04/29/25 at 5:40 P.M., 04/29/25 at 5:44 P.M., and 04/30/25 at 7:07 A.M. revealed the facility staff members did not answer the telephone and there was not a way to leave a message.</p> <p>Interview on 04/30/25 at 1:18 P.M., Registered Nurse #60 reported at times she was not able to answer the phone if they were short staffed. She continued that she did try to return the calls if she was able.</p> <p>Interview on 04/30/25 at 2:00 P.M., Ombudsman #47 reported she had received complaints from family members regarding facility staff not answering the telephones. He continued that he had reported the concern to the facility in the past.</p> <p>Phone interview on 04/30/25 at 2:20 P.M., Family Member #48 reported she had attempted to contact the facility on numerous occasions, attempting to check on her family member. She reported several times she was not been able to get ahold of anyone at the facility. She reported one weekend, she had tried for two days to get an update on her family member and was unable to get anyone to answer the phone. She reported she had to call the police department to do a wellness check on her family member. She also reported that she had outside doctors call her asking questions about her family members because they reported they were unable to get in contact with anyone at the facility.</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
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<p>F 0562</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 04/30/25 at 3:00 P.M. Resident #23 reported he had called the facility numerous times, and no one would answer the calls. A couple of weeks ago he waited 90 minutes for someone to answer his call light. He reported that they did not respond so he attempted to call the facility to get someone to help him. He went on to say no one would answer his phone call so he had to call the police to see if he could get someone to help him. He reported he felt fearful when no one answered his calls.</p> <p>Interview on 05/01/25 at 12:20 P.M. with the Administrator reported she was aware of concerns related to contacting the facility via telephone, but thought they had been resolved. She went on to say she was unaware of issues with the phone system on 04/29/25 and 04/30/25.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00164268 and Complaint Number OH00163222.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure Resident #43 received the correct oxygen dosing and failed to ensure Resident #5's nebulizer equipment and mouthpiece were appropriately stored. This affected two out of three residents reviewed for respiratory care. The facility census was 45.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #43 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, dementia, dysphagia, and diabetes mellitus type two.</p> <p>Review of Resident #43's physician orders revealed an order dated 03/15/25 for continuous oxygen at two liters per minute via nasal cannula.</p> <p>Review of Resident #43's care plan dated 04/02/25 revealed the resident had an alteration in respiratory function and required oxygen use with an intervention to administer oxygen as ordered.</p> <p>Review of Resident #43's Treatment Administration Record revealed facility nurses signed off that the resident oxygen was set to two liters on both 04/29/25 and 04/30/25.</p> <p>Observations made on 04/29/25 at 9:25 A.M., 04/29/25 at 11:25 A.M., and 04/30/25 at 2:30 P.M. revealed Resident #43 oxygen was at set at 3.5 liters per minute.</p> <p>Interview on 04/30/25 at 2:38 P.M., Registered Nurse #50 confirmed Resident #43's oxygen was at 3.5 liters per minute and that it should have been placed at two liters per minute. She adjusted the oxygen.</p> <p>2. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), dysphagia, and dependence on supplemental oxygen.</p> <p>Review of Resident #5's physician orders revealed orders dated 07/08/22 for Ipratropium-albuterol solution 0.5-2.5 (3) milligrams (mg) per 3 milliliter (ml) with instructions to inhale 3 ml orally every four hours as needed for COPD or shortness of breath.</p> <p>Review of Resident #5's care plan dated 04/11/25 revealed the resident had an alteration in respiratory function and required oxygen use with interventions to administer medications, oxygen and aerosol treatments as ordered. The care plan further revealed the resident had an alteration in respiratory function related to COPD with interventions to provide respiratory treatments per physician orders.</p> <p>Observation on 04/29/25 at 10:55 A.M. revealed Resident #5's nebulizer machine (a medical device used to deliver medication in the form of a mist or aerosol directly into the lungs) was sitting directly on the floor. The top of the machine was covered in an unknown dried substance. The mouthpiece was lying on top of the machine touching the top of the machine and wall.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/29/25 at 10:55 A.M., Resident #5 reported the nurses stored the nebulizer on the floor because there was not enough table space in his room. He stated he would prefer it not to be on the floor.</p> <p>Interview on 04/29/25 at 11:10 A.M., Licensed Practical Nurse (LPN) #29 confirmed the findings and moved the machine and mouthpiece from the floor to his bedside table and cleaned the top of the machine.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00164268 and Complaint Number OH00163713.</p>		