STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366339	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Lake Vista	303 North Mecca Street Cortland, OH 44410

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, the facility failed to ensure medications were stored appropriately and not left at the bed side. This affected two residents (Residents #8 and Resident #44) out of two residents reviewed for medication storage. The facility census was 39. Finding include:1.Review of Resident #8's medical record revealed an admission date of 11/22/24. Diagnosis include unspecified dementia, need for assistance with personal care, cerebral infarction, hypo-osmolality, hyponatremia and cognitive communication deficit.Review of Resident #8's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed at the time of the assessment the resident had intact cognition. They required assistance with Activities of Daily Living (ADLs) including dressing, bed mobility, and medication administration. Review of Resident #8's physician orders dated January 2026 revealed she was not ordered Tylenol Arthritis, or artificial tears. Further review of Resident #8's physician orders revealed she was ordered Tylenol 650 milligrams (mg) every six hours as needed for pain.Observation on 01/21/26 at 8:33 A.M. of Resident #8's over bed table revealed there was four Tylenol with Arthritis pills left in a medication cup and there were three bottles of artificial tears left on the night stand.Interview on 01/21/26 at 8:52 A.M. with Registered Nurse (RN) #410 confirmed the medications were left on the over bed table and on the nightstand, however RN #410 denied putting those medications on Resident #8's over bed table or on her night stand. RN #410 confirmed Resident #8 was not on Tylenol with Arthritis or artificial tears. RN #410 stated there were no residents in the facility who were responsible for giving their own medications. RN #410 stated all medications were administered by nursing staff.Interview on 01/21/26 at 11:46 A.M. with Resident #8 revealed she takes the Tylenol in her room when ever she wants to and does not inform the nurse, and she stated she will use the artificial tears when ever she wants to and does not notify the nurse.2. Review of Resident #44's medical record revealed an admission date of 01/16/26. Diagnosis include malignant neoplasm of rectum, muscle weakness, need for assistance with personal care, hyperlipidemia, hypertension, and benign prostatic hyperplasia without lower urinary tract symptoms.Review of Resident #44's physician orders dated January 2026 revealed there were no orders present allowing Resident #44 to leave medication at bedside.Review of Resident #44's progress notes dated 01/21/26 at 12:27 A.M. authored by RN #458 revealed resident was alert and oriented to person, place and time. He was able to make needs known, denied any pain or discomfort. Resident #44 his used wheeled walker with limited assist by one staff member. He required assistance with dressing, and activities of daily living.Observation on 01/20/26 at 12:17 P.M. revealed Resident #44 had two pills in a cup on bedside table. Resident #44 revealed they bring a medication for his bladder and a medication for cholesterol between 4:00 and 5:00 A.M. and that was too early. The nurses leave them in the cup on table, and when he feels more awake he will take them.Interview on 01/20/26 at 12:19 P.M. with RN #458 confirmed the medications were left at bed side and should not of been.Review of facility policy titled Medication Storage, last revised 09/14/25 revealed, the nursing home shall assure safe storage of medications. Staff shall ensure all (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescription medications and drugs, except those that are authorized to be kept at the bedside for self-administration in accordance with Resident Rights, shall be kept in locked storage areas and separate from materials that may contaminate the medicines.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy and interviews, the facility failed to ensure resident medical records were documented accurately. This affected one Resident (#39) out of two residents reviewed for closed record review. The facility census was 39.Findings include:Review of the closed medical record for Resident #39 revealed an admission date of 12/21/25. Admitting diagnosis included cardiomegaly, urinary tract infection, acute vaginitis, bradycardia, edema, hypokalemia, and chronic obstructive pulmonary disease (COPD).Review of the Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had intact cognition.Review of the progress note dated 01/03/26 timed 2:15 P. M. by Registered Nurse (RN) #503 revealed Resident #39 was having weakness, lethargy, and confusion along with having a hard time holding object and staying awake. Resident #39's husband was at bedside and requested resident to be seen at emergency room. Nurse practitioner (NP) on call was contacted and provided authorization to send the resident to the emergency room for evaluation and treatment.Further review of the medical record revealed a discharge date of 01/03/26. There was no evidence Resident #39 had returned to the facility or was available for medication/treatment administration on 01/05/26.Review of the Medication Administration Record (MAR) for Resident #39 revealed on 01/05/26 medications were signed off as administered for Alvesco HFA Aerosol Inhaler 80 mcg/Actuation, Calcium with Vitamin D 600 mg-10 mcg tablet, Cholecalciferol 25 mcg capsule, Eliquis 5 mg tablet, Flecainide 100 mg tablet, Miconazorb AF 2% powder, multivitamin tablet, Prevacid 24hr 15 mg capsule and, saline mist aerosol spray 0.65% on day shift (7:00 A.M.-7:00 P.M,) by RN# 410.Review of the Treatment Administration Record (TAR) for Resident #39 revealed on 01/05/26 the following treatments were signed off as completed applied ted hose to bilateral lower leg (BLE) in A.M., bilateral assist bars available, pressure reduction cushion to wheelchair was in place, head of bed (HOB) elevated, obtained full set of vital signs, monitored for signs and symptoms of dehydration, change in electrolytes, acute kidney injury, monitored for signs and symptoms of bleeding related to anticoagulation therapy, completion of oral care, and ensured protective barrier after each incontinence episode on day shift (7:00 A.M.-7:00 P.M.) by RN #410.Interview with Interim Director of Nursing (DON) #494 on 01/22/26 at 11:05 A.M. confirmed Resident #39 was discharged on 01/03/25 without readmission to facility, DON #494 also confirmed RN #410 as the initials listed on MAR and TAR dated 01/05/26 as administering medications and treatments for Resident #39 listed above.Review of facility policy titled Electronic Clinical Documentation revised date 05/20/22 revealed when a medication was not administered to a resident, the administering individual would indicate not administered and document the reason the medication was not administered in MAR.Review of facility policy titled Medication Administration General Guidelines dated 2007 revealed the individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. The policy also revealed if a dose of regularly scheduled medication was withheld the nurse shall document in the electronic medication administration record that the dose was withheld and enter and explanatory note.Review of MAR and TAR information key revealed correct documentation for a missed medication and missed treatment administering individual's initials were to be in parentheses with explanation directly below each missed individual medication and treatment missed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and facility policy review, the facility failed to maintain proper infection control practices during medication administration. This affected one Resident (Resident #17) out of four residents observed for medication administration. The facility census was 39. Finding include: Review of Resident #17's medical record revealed an admission date of 12/02/25. Diagnosis included congestive heart failure, cystitis, anemia, anxiety disorder, unspecified pain, vitamin deficiency, and chronic respiratory issues. Review of Resident #17's admission Minimum Data Set (MDS) 3.0 dated 12/02/25 revealed he was cognitively intact, required assistance by at least one staff member for all Activities of Daily Living (ADLs) including bed mobility, medication administration, dressing, showering, toileting and ambulation. Observation made during medication administration on 01/21/26 at 8:53 A.M. while preparing medications for Resident #17, Registered Nurse (RN) #410 sanitized her hands with liquid hand sanitizer, she then proceeded to touch the keys to the medication cart, the medication cards, computer screen and the medication cup. RN #410 then while checking the medications to the orders she popped each the pills one by one directly into her bare hand without re-sanitizing them, she then proceeded to place all the medications in the a medication cup, then dumped the cup into a pouch in order to crush the medications and placed them into apple sauce and administered them to Resident #17. Interview on 01/21/26 at 9:00 A.M. with RN #410 confirmed she did not perform proper hand hygiene when administering medications to Resident #17. Review of facility policy titled Medication Administration General Guidelines, last revised January 2025 revealed proper hand hygiene is to be used including washing your hands with soap and water, or use hand sanitizer and allow for dry time as well as when handling all medications gloves are to be worn.