

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Villa Vista Royale LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 Sinclair Avenue Steubenville, OH 43953	

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** 51519</p> <p>Based on observation, interviews, record review, and policy review the facility failed to assess and monitor a resident's edema while having a sling and brace in place for a humerus fracture. This affected one resident (#249) of 24 resident records reviewed for assessments.</p> <p>Findings include:</p> <p>Review of record revealed Resident #249 was admitted to the facility on [DATE] with diagnoses including left humerus fracture, hypertension (HTN) atrial fibrillation, generalize anxiety disorder, major depressive disorder, Gastrointestinal reflux disease (GERD), type 2 diabetes, heart failure, cerebrovascular disease, hyperlipidemia, anemia, mitral stenosis, lymphedema, atherosclerotic heart disease, abnormal weight loss, Transient ischemic attack (TIA), breast cancer, hypothyroid, dry eyes, cataracts, polyarthritis, hyponatremia, diverticulitis left breast lumpectomy with lymph node sampling, lumpectomy of right breast.</p> <p>Review of baseline care plan completed 03/25/25 revealed Resident #249 required two assist with ambulation and transfers, one assist with bathing and hygiene, and a one assist with dressing and grooming. Resident #249 needed assistance with setup for meals, two assist for toileting, and used a wheel chair. Goals included observing pain and report as indicated, administer pain medication as ordered, and attempt non-medication interventions. Resident is able to communicate wants and needs. Visual ability indicates Resident #249 used glasses and will have adequate vision. Resident was alert to person, place, and time. Resident has anxiety and depression and will have a safe comfortable environment, social service visit and encouraged to ventilate feelings, provide redirection for episode behavior, monitor for medication effectiveness and side effects, and provide emotional support. Consult physical therapy (PT) and occupational therapy (OT) as ordered, evaluate for unsteady gate, ambulation devices as necessary, call bell within reach, observe footwear and non-skid socks. Prevent pressure ulcer and skin break down by following facility skin protocol, turn and position PRN, weekly skin evaluation, report any redness to medical director (MD), keep linens dry and wrinkle free, do prescribed treatment as ordered, notify MD is treatment is ineffective.</p> <p>Record review of Emergency department physician notes dated 03/23/25 revealed Resident #249 arrived from home due to a fall from ground level from standing position onto her left side, states she has left shoulder pain. Left arm x-ray revealed an acute humerus fracture. Left humeral sugar-tong splint placed to left humerus for stabilization.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of progress notes revealed a note on 03/25/25 at 6:00 P.M. by Licensed Practical Nurse (LPN) that identified Resident #249 had a brace and sling to left upper extremity (LUE) with pitting +2 edema to left hand. States brace/ sling can be removed for care. Resident is in good spirits with pain upon movements.</p> <p>Record Review of a comprehensive nursing note written on 03/26/25 by Registered Nurse (RN) #123 at 5:47 P.M. revealed nonpitting edema to LUE due to lymphedema. Sling in place per order to LUE.</p> <p>Record review of comprehensive nursing notes revealed no documentation of Resident #249's edema to the LUE on comprehensive nursing notes completed on 03/25/25, 03/27/25, 03/28/25, 03/29/25, 03/30/25, 03/31/25, 04/01/25, and 04/02/25.</p> <p>Record review revealed no documentation of monitoring or evaluation of Resident #249's LUE edema.</p> <p>Record review revealed no documentation of interventions ordered or being implemented for Resident #249 LUE edema.</p> <p>Observation on 03/31/25 at 11:10 A.M. revealed Resident #249's arm in a brace and sling, only able to visualize Resident #249's hand with swelling to the left hand.</p> <p>Observation on 4/01/25 at 11:21 A.M. revealed Resident #249 moving herself down the hallway in her wheelchair with a brace and sling applied to the LUE. Unable to visualize LUE from the wrist up. Swelling noted to the left hand of Resident #249.</p> <p>Observation on 04/02/25 at 9:05 A.M. revealed Resident #249 and RN #123 speaking. Observed sling and brace to Resident #249's LUE. Unable to visualize Resident #249's LUE from wrist up. Resident #249 had swelling to the left hand.</p> <p>Interview on 04/02/25 at 10:26 A.M. with Registered Nurse (RN) #123 revealed that Resident #249's arm had been swollen due to her lymphedema and was swollen on previous admissions. RN#123 stated before they were able to elevate her arm, but therapy has Resident #249 limited on what she can do with her left arm and they are only able to take the brace off for care. RN #123 stated the edema should be documented in the comprehensive nursing assessment.</p> <p>Interview on 04/02/25 at 10:13 A.M. with Occupational Therapy Assistant (OTA) #555 revealed Resident #249 is coming to therapy 3-5 times a week, they've had a few sessions and are working on exercises Resident #249 can do while seated, improving range of motion to her left upper extremity, and hand exercises to help with the edema in that arm.</p> <p>Interview with RN #111 on 04/02/25 at 2:20 P.M. stated that the edema on the arm should be documented. RN #111 stated she understands it is necessary to evaluate the swelling to monitor for any changes especially with the sling and the fracture to the extremity.</p> <p>Review of policy Charting and Documentation (revised July 2017) revealed treatments or services performed must be documented in the medical record, documentation will be objective (not opinionated or speculative), complete, and accurate. Documentation will include care specific details including the assessment data and any unusual findings obtained during the procedure/treatment.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801</p> <p>Based on medical record review, observation, restorative master log, review of the therapy log, and interview the facility failed to ensure a newly admitted resident was accurately assessed for range of motion (ROM) and failed to ensure an individualized restorative program was implemented to ensure the resident maintained range of motion. This affected one resident (#399) of three reviewed for ROM.</p> <p>Findings included:</p> <p>Medical record review revealed Resident #399 was transferred to the facility on [DATE] from another skilled nursing facility located in another state. The resident diagnoses included stiffness of unspecified joint, absence of right leg above knee, diabetes type two, hemiplegia and hemiparesis following cerebral infarction affecting right dominating side, lack of coordination, weakness, and difficulty walking.</p> <p>Review of Resident #399's base line care plan dated 03/01/25 revealed the resident's bilateral hands the fingers (last two) only opened 50-75%. There were no goals or interventions documented.</p> <p>Review of Resident #399's comprehensive plan of care revealed no evidence of a plan of care for limited ROM/contractures.</p> <p>Review of admission Minimum Data Set (MDS) dated [DATE] revealed the resident had no impairment of the upper extremity and impairment one side of the lower extremity.</p> <p>Review of Resident #399's mobility evaluation dated 03/07/25 revealed the resident had full range of motion of right and left fingers.</p> <p>Review of Resident #399's orders and task (CNA documentation) revealed no evidence the resident had orders for splints, braces, or restorative therapy.</p> <p>Review of restorative master log sheet dated 04/2025 revealed no evidence Resident #399 was receiving restorative services.</p> <p>Review of the Therapy log dated 04/2025 revealed no evidence Resident #399 was receiving therapy services.</p> <p>Interview and observation with Resident #399 on 03/31/25 at 10:29 A.M. and 04/01/25 at 8:25 A.M., revealed the resident had contractures noted right pinky and left ring finger and pinky. The resident confirmed he had not received therapy, splints, or any type of treatment to prevent contractors in his fingers from getting worse since he had been admitted to the facility a month ago. The resident reported he was in a skilled nursing home in another state and was not receiving good care which resulted in his fingers being contracted. The resident reported he was hoping to have therapy and they would put something in place but he has not seen therapy yet.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and observation on 04/01/25 at 1:25 P.M. of Resident #399 with Licensed Practical Nurse (LPN) #110 and Certified Nursing Assistant (CNA) #148 confirmed Resident #399's right pinky and left ring finger and pinky were contracted. The LPN attempted to straighten out the resident fingers, however, was not able due to the extent of the contractures and the resident was experiencing pain. The LPN was not able to open fingers more than halfway on the right and less than halfway one the left. The CNA (who was related to Resident #399) and resident confirmed the contractures had not worsened in the last 30 days.</p> <p>Interview on 04/01/25 at 1:42 P.M., with LPN/Restorative Nurse #300 confirmed Resident #399's admission MDS and mobility evaluation were inaccurate due to the resident having limited ROM/contracture with his fingers on admission per the baseline plan of care and resident interview. The LPN confirmed the resident did not have a comprehensive plan of care for the limited range of motion/contractors nor was in a restorative program/therapy initiated, however a program should have been initiated. LPN #300 confirmed the resident was not receiving therapy services.</p> <p>Review of Resident #399's MDS note dated 04/01/25 (after surveyor confirming findings with staff) revealed the resident stated he would enjoy having exercise to his joints. The resident stated his ROM had not declined since admission. The resident had noted limitation to his pink finger on the right hand and last two fingers on the left hand. The resident reported the limitation happened at the place he was prior to coming to the facility. Will add ROM program.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801</p> <p>Based on medical record review, interview, and policy review the facility failed to ensure laboratory testing was completed per physician order. This affected one resident (#28) of five residents reviewed for medication review.</p> <p>Findings included:</p> <p>Medical record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including history of hypertension, grade I diastolic dysfunction, and dementia.</p> <p>Review of Resident #28's orders dated 03/2025 revealed on 10/28/22 the physician ordered lipid profile to be obtained every six months (April/October).</p> <p>Review of laboratory results dated [DATE] to 04/01/25 revealed no evidence a lipid profile was obtained per orders in October 2024.</p> <p>Further review of laboratory results revealed the last lipid profile was obtained on 04/05/24. The resident's cholesterol was 250 (high) (normal less than 200 milligram (mg) / deciliters (dL), triglyceride 234 high (normal less 150 mg/dl), HDL 36.0 low (higher than desirable 40 mg/dl), LDL 167 high (less than 100 if desirable if clinical atherosclerotic disease or diabetes had been diagnosed).</p> <p>Review of the facility policy titled Lab Draw dated 01/2025 revealed labs would be drawn as ordered by the physician.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701</p> <p>Based on medical record review, policy review and staff interview the facility failed to ensure residents had appropriate indications for use of antibiotics. This affected one resident (#20) of five residents reviewed for antibiotic use. The facility census was 50.</p> <p>Findings include:</p> <p>Review of Resident #20's medical record revealed an admitted [DATE] with diagnoses that included diabetes mellitus, hypertension and peripheral vascular disease.</p> <p>Review of Resident #20's nursing notes revealed on 11/01/24 the resident sustained a fall and was sent to the local emergency department for evaluation. Upon return to the facility on [DATE], Resident #20 was diagnosed at the emergency department with a urinary tract infection (UTI) and prescribed Cephalexin (antibiotic) 500 milligrams (mg) every six hours for five days due to a UTI. Nursing staff advised Resident #20's physician of the returning diagnosis and antibiotic order. Nursing staff also advised the physician the resident's urinalysis was negative and resident asymptomatic for a UTI. Resident #20's physician advised staff to continue the antibiotic. On 11/04/24, after receiving the final urinalysis results, the physician was notified Resident #20 did not meet criteria and advised to continue the antibiotic as ordered.</p> <p>Review of the physician's medication orders revealed on 11/02/24 Resident #20 was prescribed the use of Cephalexin (antibiotic) 500 milligrams (mg) every six hours for five days due to a urinary tract infection (UTI).</p> <p>Review of the antibiotic assessment completed on 11/02/24 revealed Resident #20 did not meet McGeer's criteria for appropriate indication for antibiotic use. The assessment indicated Resident #20 had a urinalysis and culture that final results returned on 11/03/24 which indicated a bacteria growth of proteus mirabilis of >100,000 colonies per million (cfu/ml). The resident had no additional symptoms of a UTI.</p> <p>Review of facility policy titled Antibiotic Stewardship with a reviewed date of December 2016 revealed antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program.</p> <p>Additional policy review titled Infection Prevention and Control; Antibiotic Stewardship with a review date of June 2024 revealed the facility administration and medical director should ensure that current standards of practices based on recognized guidelines are incorporated in the residents care policies and procedures.</p> <p>Interview with the Director of Nursing on 04/02/25 at 2:25 P.M. verified the antibiotic for Resident #20 on 11/02/25 did not meet criteria for appropriate indication for use.</p>		