STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365185	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Center Healthcare and Rehabilitation	5665 South Ave Youngstown, OH 44512

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on record review, interview and review of the facility policy the facility failed to ensure Resident #45's responsible party was included in the development and revision of the care plan for Resident #45. This affected one resident (Resident #45) out of three residents reviewed for participation in care planing. The facility census was 92. Findings include: Review of Resident #45's medical record revealed an admitted [DATE] and diagnoses including Alzheimer's disease, white matter disease (damage to the brain's white matter caused by reduced blood flow to the tissues), anxiety disorder, chronic ischemic heart disease and type two diabetes without complications. Review of Resident #45's Annual Minimum Data Set 3.0 assessment dated [DATE] included Resident #45 had severe cognitive impairment. Resident #45 required supervision or touching assistance for toileting hygiene and setup or clean-up assistance with personal hygiene. Resident #45 was independent for eating, upper and lower body dressing, bed mobility and walking ten feet. Resident #45 required supervision or touching assistance for transfer from bed to chair or wheelchair, and toilet transfer. Resident #45 was always continent of urine and bowel. Review of Resident #45's care plan dated 11/07/23 and revised on 11/19/24 included neurological deficiencies related to white matter signal abnormalities which were likely the sequela of chronic small vessel disease, Alzheimer's dementia. Resident #45 would have ADL (Activity of Daily Living) needs met with staff assistance. Resident #45 would maintain the ability to participate in all ADL's and activities of choice as condition permitted. Interventions included to obtain labs and diagnostic tests as ordered and notify the physician of results; to obtain vital signs as clinically needed; to report signs or symptoms of tremors, rigidity, dizziness, changes in level of consciousness and slurred speech. Review of Resident #45's care plan dated 11/07/23 and revised on 12/16/24 included Resident #45 had an ADL self care deficit related to cognitive loss in dementia, generalized muscle weakness, unsteady gait, ischemic heart disease, type two diabetes and moderate malnutrition. Resident #45 would be clean, dressed and well groomed daily to promote dignity and psychosocial well-being. Interventions included toileting required supervision and verbal cues; Resident #45 was independent for bed mobility and ambulation required supervision and verbal cues. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #45's social services notes dated 02/15/24, 05/16/24 and 08/16/24 revealed Resident #45 was reviewed for quarterly assessments and the notes included Resident #45's care plan was reviewed and updated and Resident #45 and her family were made aware of any changes to the care plan. Review of Resident #45's social services notes and progress notes dated 08/16/24 through 01/23/25 did not reveal evidence Resident #45 was reviewed for a quarterly assessment related to planning care which included the resident representative. Interview on 01/23/25 at 9:47 A.M. of Family Member (FM) #672 revealed she was Resident #45's Power of Attorney and Resident #45 had a change in condition and decline in Activity of Daily Living's and no one from the facility called her to discuss these issues or to set up a care conference. FM #672 stated when she was at the facility it was hard to find a nurse or aide to ask questions and address her concerns. FM #672 stated she did not think Resident #45 required a secured unit now, and would prefer her to be off the unit and would like to discuss the possibility with facility staff, but no one ever called her. FM #672 indicated she was only invited by the facility to one care conference and that was close to when Resident #45 was first admitted to the facility. FM #672 stated she had not been invited to a care meeting for about a year. Interview on 01/23/25 at 11:04 A.M. of Social Services Director (SSD) #617 revealed care conferences were completed every three months and per request. SSD #617 stated she worked with Registered Nurse/Minimum Data Set (RN/MDS) #624 to plan and conduct resident care conferences. SSD #617 stated RN/MDS #624 either placed a phone call or sent an email to invite responsible parties to resident care conferences. SSD #617 indicated Power of Attorney's were included and invited to resident care conferences. SSD #617 confirmed Resident #45 did not have a care conference since 08/16/24. Interview on 01/23/25 at 10:15 A.M. of RN/MDS #624 revealed she sent letters and made phone calls to invite resident's responsible parties to the care conferences. RN/MDS #624 stated if she did not have an address to send a letter then she made a phone call to the responsible party. RN/MDS #624 stated care conferences were documented in the progress notes, and she documented if she mailed letters or made phone calls to responsible parties. RN/MDS #624 indicated she reviewed Resident #45's medical record including progress notes and did not see where she documented she placed a phone call, left messages or sent a letter to FM #672 who was Resident #45's POA for care conferences on 02/15/24, 05/16/24 and 08/16/24 . RN/MDS #624 confirmed there should have been a care conference in October 2024 and there wasn't. RN/MDS #624 stated Resident #45's last care conference was 08/16/24. Review of the facility policy titled Care Planning Interdisciplinary Team, dated 12/2008, revealed the resident and resident representative are encouraged to participate in the development of and revisions to the resident care plan. Every effort will be made to schedule care plan meetings at the best time of day for the resident and family. Care plans shall incorporate goals and objectives that lead to the resident's highest attainable level of independence. This deficiency represents noncompliance identified during investigation of Complaint Number OH00161689

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #45's change in condition was reported to Resident #45's primary care physician and responsible party in a timely manner. This affected one resident (Resident #45) out of three residents reviewed for change of condition. The facility census was 92. Findings include: Review of Resident #45's medical record revealed an admitted [DATE] and diagnoses included Alzheimer's disease, white matter disease (damage to the brain's white matter caused by reduced blood flow to the tissues), anxiety disorder, chronic ischemic heart disease and type two diabetes without complications. Review of Resident #45's Annual Minimum Data Set 3.0 assessment dated [DATE] included Resident #45 had severe cognitive impairment. Resident #45 required supervision or touching assistance for toileting hygiene and setup or clean-up assistance with personal hygiene. Resident #45 was independent for eating, upper and lower body dressing, bed mobility and walking ten feet. Resident #45 required supervision or touching assistance for transfer from bed to chair or wheelchair, and toilet transfer. Resident #45 was always continent of urine and bowel. Review of Resident #45's care plan dated 11/07/23 and revised on 11/19/24 included neurological deficiencies related to white matter signal abnormalities which were likely the sequela of chronic small vessel disease, Alzheimer's dementia. Resident #45 would have ADL (Activity of Daily Living) needs met with staff assistance. Resident #45 would maintain the ability to participate in all ADL's and activities of choice as condition permitted. Interventions included to obtain labs and diagnostic tests as ordered and notify the physician of results; to obtain vital signs as clinically needed; to report signs or symptoms of tremors, rigidity, dizziness, changes in level of consciousness and slurred speech. Review of Resident #45's care plan dated 11/07/23 and revised on 12/16/24 included Resident #45 had an ADL self care deficit related to cognitive loss in dementia, generalized muscle weakness, unsteady gait, ischemic heart disease, type two diabetes and moderate malnutrition. Resident #45 would be clean, dressed and well groomed daily to promote dignity and psychosocial well-being. Interventions included toileting required supervision and verbal cues; Resident #45 was independent for bed mobility and ambulation required supervision and verbal cues. Review of Resident #45's progress notes dated 01/12/25 at 12:51 P.M. included Resident #45 needed increased assistance with ADL's. Extensive assistance was needed with all transfers, Resident #45 was incontinent of bladder and incontinence care was provided as needed. Resident #45 required extensive assistance with feeding. Much cueing was provided and was ineffective. Staff fed Resident #45 breakfast and lunch. Therapy services informed. There was no evidence Resident #45's physician or responsible party were notified. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #45's progress notes dated 01/13/25 at 8:11 A.M. revealed on 01/13/25 at 12:04 A.M. Resident #45 appeared fatigued during medication administration, and signs of lethargy despite having vital signs within normal limits. Resident #45 reported feeling more tired than usual but had no complaints of pain or discomfort. The on call Nurse Practitioner (NP) (unidentified) was notified to discuss the situation and the NP ordered laboratory tests including Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) in the morning. There was no evidence Resident #45's responsible party was notified. Review of Resident #45's physician progress notes dated 01/13/25 written by Nurse Practitioner (NP) #670 included nursing endorsed Resident #45 had increased fatigue, confusion, weakness and needed increased assistance with ADL's. The on call NP was contacted and a CBC and CMP were ordered STAT (immediately). Upon exam Resident #45 denied shortness of breath, chest pain, lightheadedness, dizziness, headache, nausea, vomiting, diarrhea. Resident #45 endorsed she had constipation with no tenderness upon palpation to abdomen. There was no mention of Resident #45's bladder incontinence. Review of Resident #45's physician progress notes dated 01/14/25 written by NP #670 included Resident #45 was seen yesterday and noted to have tachycardia, electrocardiogram (EKG) was ordered and was pending. Resident #45's kidney, ureter, bladder (KUB) test ordered on 01/13/25 for complaints of constipation and hypoactive bowel sounds revealed gas and a normal amount of stool was scattered throughout the colon into the rectum and the impression was nonspecific nonobstructed bowel gas pattern by plain radiography. There was no mention of Resident #45's bladder incontinence. Review of Resident #45's physician progress notes dated 01/16/25 written by NP #670 included labs were ordered due to increased muscle weakness, increased need for assistance with ADL's as well as trouble feeding self. Upon exam Resident #45 denied shortness of breath, chest pain, lightheadedness, dizziness, headaches, blurred vision, nausea, vomiting, diarrhea. There was no mention of Resident #45's bladder incontinence. Observation on 01/23/25 at 8:56 A.M. of Resident #45 sitting at a table in the common area, her head was down and resting on her arms which were placed on the table in front of her. Resident #45's hair was clean and tied back into a ponytail and her face could not be seen. Interview on 01/23/25 at 9:47 A.M. of Family Member (FM) #672 revealed she visited Resident #45 on 01/12/25 around 3:00 P.M. and she was way worse than I have ever seen her. FM #672 stated she did not receive a call from the facility about Resident #45's change of condition. FM #672 stated she was Resident #45's Power of Attorney and she was not notified by the facility nor physician that Resident #45 was incontinent and needed incontinent briefs. Interview on 01/23/25 at 11:04 A.M. of Social Services Director (SSD) #617 confirmed FM #672 contacted her on 01/13/25 and told her she visited Resident #45 over the weekend and had some concerns. SSD #617 stated FM #672 told her Resident #45 was lethargic, was not doing well, and the nurse told her labs and a urinalysis were supposed to be ordered. SSD #617 indicated FM #672 was concerned about Resident #45's overall health, and there was also a concern about her medications, but she was not sure what the issue was. SSD #617 stated she documented the concerns and reported them to to Clinical Director (CD) #506. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 11:38 A.M. of Certified Nursing Assistant (CNA) #538 revealed Resident #45 used to be independent and now she was confused, incontinent, not eating, sleepy, always tired and this was a big change for her. CNA #538 confirmed the nurses were aware of it. Interview on 01/23/25 at 11:43 A.M. of Registered Nurse (RN) #611 revealed Resident #45 had declined, she used to walk and use a rollator then she went to the wheelchair recently. RN #611 confirmed Resident #45 was incontinent now and that was a change for her. RN #611 stated she had not talked to FM #672 or updated her about Resident #45's changes in condition. Interview on 01/23/25 at 2:24 P.M. of NP #670 revealed she was not notified on 01/12/25 of a change in Resident #45's condition, but became aware of it on 01/13/25. NP #670 stated on 01/13/25 the on call Nurse Practitioner was notified early in the morning and she became aware later in the day. NP #670 stated she did not know if Resident #45 had a urinalysis completed. NP #670 indicated she was not told by the staff that Resident #45 was incontinent and she did not order a dip stick to check for a urine infection or a urinalysis or a urine culture and sensitivity. NP #670 stated there was nothing in her notes about Resident #45 having urinary incontinence and she was unaware of it. NP #670 stated she could not be in the facility 24/7. Interview on 01/23/25 at 3:32 P.M. of SSD #617 revealed FM #672 called her on 01/13/25 and asked about lab results for Resident #45's urinalysis and other lab results that were drawn and she reported this in a meeting on 01/16/24. SSD 3617 stated she told CD #506 to let FM #672 know about Resident #45's lab results and CD #506 stated she would follow up. Interview on 01/23/25 at 3:45 P.M. of CD #506 revealed she was notified FM #672 was asking about Resident #45's labs and urinalysis, but she got busy and forgot to call FM #672. CD #506 stated she checked a book she kept which had her to do list in it and confirmed she did not call FM #672. CD #506 stated she felt really badly she did not call FM #672 and confirmed FM #672 was not contacted regarding Resident #45's change in condition on 01/12/25 at 12:51 P.M. or 01/13/25 at 12:04 A.M. CD #506 confirmed neither Resident #45's physician or Nurse Practitioner were contacted on 01/12/25 regarding Resident #45's change of condition and they should have been notified. CD #506 indicated she did not contact NP #670 and report Resident #45 was incontinent and she was not aware if other nurses had contacted NP #670 about her incontinence. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Notification of Significant Change in Resident Condition undated included the policy was established to ensure family members or designated [NAME] of Attorney (POA) were promptly notified in the event of a significant change in the condition of a resident within the Skilled Nursing Facility (SNF). Timely communication with family members or POA was essential for maintaining transparency, facilitating decision-making and ensuring the well-being of residents. The policy applied to all staff members responsible for the care and monitoring of residents within the SNF, including nursing staff, physicians and administrative personnel. A significant change in resident condition included but was not limited to changes in medical status, such as new diagnoses, exacerbation of existing conditions, or unexpected deterioration; changes in mental or cognitive status, such as confusion, agitation, or a significant decline in memory or functioning; any other change that might impact the resident's health, safety, or quality of life. In the event of a significant change in resident condition, the primary nurse or attending physician was responsible for promptly notifying the resident's family member or designated POA. Notification should occur within a reasonable timeframe, typically within 24 hours of the change being identified or as soon as practically possible. All notification to family members or POA regarding significant changes in resident condition must be documented in the resident's medical record. Following the initial notification, staff members should provide regular updates to the resident's family member or POA as appropriate, keeping them informed of any changes in the resident's condition or care plan. Staff should be available to answer questions, address concerns, and provide support to the family member or POA throughout the process. This deficiency represents noncompliance identified during investigation of Complaint Number OH00161689.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of bowel and bladder assessments the facility failed to ensure Resident #45 was provided toileting assistance to maintain a level of ability with toileting activity of daily living. This affected one resident (Resident #45) out of three residents reviewed for Activity of Daily Living's. The facility census was 92. Findings include: Review of Resident #45's medical record revealed an admitted [DATE] and diagnoses included Alzheimer's disease, white matter disease (damage to the brain's white matter caused by reduced blood flow to the tissues), anxiety disorder, chronic ischemic heart disease and type two diabetes without complications. Review of Resident #45's Bowel and Bladder Continence Evaluation dated 09/16/24 revealed Resident #45 had high restorative potential (retraining). Review of Resident #45's Annual Minimum Data Set assessment dated [DATE] included Resident #45 had severe cognitive impairment. Resident #45 required supervision or touching assistance for toileting hygiene and setup or clean-up assistance with personal hygiene. Resident #45 was independent for eating, upper and lower body dressing, bed mobility and walking ten feet. Resident #45 required supervision or touching assistance for transfer from bed to chair or wheelchair, and toilet transfer. Resident #45 was always continent of urine and bowel. Review of Resident #45's care plan dated 11/07/23 and revised on 11/19/24 included neurological deficiencies related to white matter signal abnormalities which were likely the sequela of chronic small vessel disease, Alzheimer's dementia. Resident #45 would have ADL (Activity of Daily Living) needs met with staff assistance. Resident #45 would maintain the ability to participate in all ADL's and activities of choice as condition permitted. Interventions included to obtain labs and diagnostic tests as ordered and notify the physician of results; to obtain vital signs as clinically needed; to report signs or symptoms of tremors, rigidity, dizziness, changes in level of consciousness and slurred speech. Review of Resident #45's Bowel and Bladder Continence Evaluation dated 12/16/24 revealed Resident #45 had moderate restorative potential (habit/prompted). Resident #45 was continent of bowel and usually continent of urine with occasional incontinence but not daily. Review of Resident #45's medical record including progress notes and evaluations did not reveal evidence Resident #45 had a trial of a toileting program attempted (scheduled toileting, prompted voiding, bladder training). (continued on next page)

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #45's care plan dated 11/07/23 and revised on 12/16/24 included Resident #45 had an ADL self care deficit related to cognitive loss in dementia, generalized muscle weakness, unsteady gait, ischemic heart disease, type two diabetes and moderate malnutrition. Resident #45 would be clean, dressed and well groomed daily to promote dignity and psychosocial well-being. Interventions included toileting required supervision and verbal cues; Resident #45 was independent for bed mobility and ambulation required supervision and verbal cues. Review of Resident #45's care plan dated 11/07/23 and revised on 12/16/24 did not reveal a care plan to assist with bowel and bladder continence. Review of Resident #45's progress notes dated 12/16/24 through 01/12/25 did not reveal documentation Resident #45 was incontinent, had a trial toileting program or a toileting program was currently being used to manage Resident #45's bladder incontinence. Review of Resident #45's progress notes dated 01/12/25 at 12:51 P.M. included Resident #45 needed increased assistance with ADL's. Extensive assistance was needed with all transfers, Resident #45 was incontinent of bladder and incontinence care was provided as needed. Observation on 01/23/25 at 8:56 A.M. of Resident #45 sitting at a table in the common area, her head was down and resting on her arms which were placed on the table in front of her. Resident #45's hair was clean and tied back into a ponytail and her face could not be seen. Interview on 01/23/25 at 9:35 A.M. of Family Member (FM) #672 revealed she was Resident #45's Power of Attorney (POA). FM #672 stated Resident #45 was in diapers now. FM #672 stated she did not know if the aides attempted to take Resident #45 to the bathroom on a schedule to help keep her continent, but when Resident #45 stopped being able to go to the bathroom she noticed she started wearing diapers. FM #672 stated she was not told by facility staff Resident #45 was wearing incontinence briefs and she had no idea she was wearing them until an aide told her she needed to change Resident #45's incontinence brief. Interview on 01/23/25 at 11:43 A.M. of Registered Nurse (RN) #611 revealed Resident #45 had declined and was now incontinent. RN #611 stated she did not know if Resident #45 had a trial toileting program initiated and completed. RN #611 confirmed she did not talk to FM #672 regarding Resident #45's bladder incontinence. Interview on 01/23/25 at 2:04 P.M. of Clinical Director (CD) #506 revealed she completed Resident #45's Bowel and Bladder Evaluation on 09/16/24 and 12/16/24 and acknowledged she had a change from high restorative potential (retraining) to moderate restorative potential (habit/prompted). CD #506 indicated the aides and nurses on the unit assisted Resident #45 to the bathroom but there was no scheduled toileting program. CD #506 stated interventions to assist with continence could be placed in Resident #45's electronic record by either herself or another nurse, and she did not have a good answer for why it was not done. CD #506 stated she completed Resident #45's Bowel and Bladder Evaluations but did not do anything further once the evaluations were finished. CD #506 confirmed Resident #45 had a decline in her continence in a short period of time and had no idea why and thought maybe her disease process is catching up to her. Interview on 01/23/25 at 4:02 P.M. of the Director of Nursing confirmed no scheduled toileting program for Resident #45 was implemented and (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45 went from a high to a moderate restorative potential for bladder and bowel continence and it would have been a good idea to put a plan in place, but it did not happen. The DON stated the aides took Resident #45 to the bathroom but not on a schedule. Interview on 01/23/25 at 4:16 P.M. of Occupational Therapist (OT) #671 revealed she worked with Resident #45 due to shoulder pain limiting her function. OT #671 stated Resident #45 declined about halfway through therapy, became weak and could not safely walk any longer and was started on wheelchair management. OT #671 stated incontinence was not brought to her attention as an issue and she did not work with Resident #45 for incontinence. This deficiency represents noncompliance identified during investigation of Complaint Number OH00161689.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47570 Based on observation, record review and interview the facility did not ensure palatable food was served at residents meals. This affected four residents (Resident #11, #32, #69 and #90) of six residents reviewed for food/nutrition. The facility census was 92. Findings include: Interview was conducted on 01/21/25 at approximately 9:25 A.M. with Licensed Practical Nurse (LPN) #577 who stated the residents do complain about the food being served cold and not hot enough. Interviews were conducted on 01/21/25 from 9:30 A.M. to 10:10 A.M. with Resident #69, #90, #32 and #11. Resident #69, #90 and #11 stated the hot food was served cold and was not always palatable. Resident #32 stated she had received spoiled milk and the food is sometimes too hard. Observation of tray line on 01/21/25 from 12:15 P.M. through 12:47 P.M. revealed food was above 165 degrees Fahrenheit (F) at the start of tray line. A test tray was requested as the last resident's food was plated. The food cart left the kitchen at 12:47 P.M. and arrived at the unit at 12:48 P.M. When the last tray on the cart was delivered on 01/21/25 at 1:06 P.M., the test tray was removed from the food cart and placed on a table when food temperatures were taken. Dietary Manager (DM) #634 took the temperatures of the food and verified the temperature for the iced tea was 48 degrees F, two percent milk was 52 degrees F, mandarin oranges 59 degrees F, pasta with sausage 138 degrees F and brussels sprouts were 120 degrees F. Upon taste test of the brussel sprouts the temperature was barely warm and not hot. Review of the facility policy titled Food and Nutrition Services, dated 10/2017, revealed each resident would be provided a nourishing, palatable diet and food service staff would ensure attractive food was served at palatable temperatures. The policy did not indicate a temperature range to maintain palatable food temperatures. This deficiency represents non-compliance investigated under Complaint Number OH00160967.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365185	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Center Healthcare and Rehabilitation	5665 South Ave Youngstown, OH 44512

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 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on observation, interview and review of facility policy the facility did not ensure a safe, functional, sanitary, and comfortable environment for all residents. This had the potential to affect all 92 residents living in the facility. Findings include: Observations were conducted on 01/21/25 from 9:30 A.M. to 10:30 A.M. and the following physical environment concerns were identified: On the 300 hallway by the telephone there were 12 holes in the drywall. The lower elevator entrance located near the activities room had excessive amount of scuff marks on the elevators interior, particularly around the kick plate. Additionally, the kick plate itself had chipped paint, and there was dark debris accumulated in each corner of the elevator. The same elevator entrance on the 300-hall had excessive scuff marks and the entrance kick plate had chipped paint. The 200 hall and 300 hall flooring had noticeable dark scuff marks and a build-up of a black, dirt-like substance along the baseboards. The 300 hall unsecured unit had a PVC pipe protruding from the wall , and the 300 hall secured unit had a PVC pipe and metal brackets extending from the wall at shoulder height. The bottom of room [ROOM NUMBER]'s door frame was detached from the wall causing the door frame to protrude. The elevator near the rehab entrance had a build-up of dark colored dirt-like substance in the corners of the flooring. The 200 hall had a missing corner piece on the hand railing exposing a sharp edge. Interviews conducted on 01/21/25 from 9:35 A.M. to 9:55 A.M. with Resident # 5, #69, #32 and #6 revealed they would like the environment to be updated. On 01/21/25 at 1:46 P.M. interview with the Housekeeping Supervisor #636 and Maintenance Director #637 verified the observations. Review of facility policy titled Quality of Life Homelike Environment dated May 2017, revealed residents would be provided a safe, clean, comfortable and homelike environment . This deficiency represents non-compliance investigated under Complaint Number OH00160967, OH00160981 and OH00159424.