

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Park Center Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure Resident #80 was provided privacy while being changed. This affected one (Resident #80) of three residents reviewed for privacy. The facility census was 93. Findings include: Review of the medical record for Resident #80 revealed an admission date of 11/08/19. Diagnoses included Alzheimer's disease, stroke affecting right dominant side, diabetes, right hand contracture, depression, arthritis and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 was moderately cognitively impaired. He required setup help for eating, supervision for oral and personal hygiene, partial assistance for showering, and substantial or maximum assistance for toileting. Observation on 08/06/25 at 2:48 P.M. revealed Resident #80's bedroom door was open. Certified Nurse Aide (CNA) #619 was assisting Resident #80 in being cleaned up after having a bowel movement. Resident #80 was rolled onto his right side, facing the door with no clothing on. The privacy curtain was not drawn. Interview on 08/06/25 at 2:53 P.M. with CNA #619 confirms she was assisting in cleaning and changing Resident #80 and did not close the door or draw the privacy curtain. Review of the facility policy titled Dignity, dated February 2021, revealed the facility would promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care.		

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: 365185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Park Center Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure a comprehensive assessment, and periodic reassessments of a seatbelt restraint were completed for Resident #88. This affected one (Resident #88) of one resident reviewed for restraints. The facility census was 93. Findings include: Review of the medical record revealed Resident #88 was admitted to the facility on [DATE] with diagnoses which included Multiple Sclerosis (MS), chronic pain syndrome, migraine, anxiety, and major depressive disorder. Review of the 07/04/25 quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #88 was alert and oriented to person, place, and time (A&Ox3). The assessment indicated Resident #88 did not have any restraints, including chair or trunk restraints. She was dependent on her wheelchair for movement around the facility. Review of the current physician orders revealed no orders for a seatbelt for Resident #88. Review of the current care plans revealed no mention of Resident #88 using a seatbelt or trunk restraint. Initial observation of Resident #88 on 08/04/25 at 10:02 A.M. revealed she was in her wheelchair with a seatbelt fastened around her stomach/abdomen. Interview on 08/05/25 at 11:34 A.M. with the Administrator and Assisting Administrator #700 revealed both agreed Resident #88 does not have a seatbelt. Interview on 08/05/25 at 3:45 P.M. with Clinical Manager #510 confirmed Resident #88 did not have a seatbelt on her wheelchair. Review of progress notes prior to 08/06/25 revealed no mention of Resident #88 utilizing a seatbelt. Observation on 08/06/25 at 1:34 P.M. of Resident #88 revealed she was in bed, relaxing after her shower. There was a seat belt on her wheelchair. Interview on 08/06/25 at 1:34 P.M. with Resident #88 reported she liked wearing the seat belt, it made her feel more secure. She sometimes felt like she was going to slide out of her chair. She stated she easily takes the seatbelt off and on herself. Interview on 08/06/25 at 1:45 P.M. with Licensed Practical Nurse (LPN) #547 and Certified Nursing Assistant (CNA) #562 revealed they were aware Resident #88 had a seatbelt on her wheelchair and liked to use it to feel more secure. They admitted there was no assessment or direction to ask Resident #88 to release the seatbelt as it was her choice to wear it. LPN #547 and CNA #562 confirmed Resident #88 could self-release the seatbelt, as she would get in and out of it multiple times a day. Interview on 08/06/25 at 2:22 P.M. with the Administrator and Assisting Administrator #700 to advise both on the presence of a seatbelt, confirmed with a second observation and staff interview. Physician order dated 08/06/25 initiated Resident #88's seat belt use. The order specified the seat belt was per resident request and preference. Resident #88 shall demonstrate the ability to effortlessly self-release the seatbelt at will and verbalize understanding of appropriate use. Record review on 08/07/25 revealed the care plan for Resident #88's Functional Status deficit added an intervention on 08/06/25 asserting the self-releasing seatbelt was per resident request/preference. Resident #88 demonstrated the ability to release the seatbelt at will. Review of the facility policy Use of Restraints, updated April 2017, asserted prior to placing a resident in restraints, there shall be a pre-restraining assessment and review. Also, an ongoing, periodic review of the resident's ability to self-release the restraint.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Park Center Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure safe smoking practices for Resident #83. This affected one (Resident #83) of five residents reviewed for smoking. In addition, the facility failed to ensure there was a fire blanket or fire extinguisher was observed in the designated smoking area. This had the potential to affect 30 (Residents #2, #4, #7, #10, #19, #23, #27, #28, #30, #31, #32, #36, #38, #42, #43, #46, #52, #65, #73, #75, #76, #78, #79, #83, #85, #86, #91, #92, #93, #94 and #96) identified by the facility as residents who smoked. The facility census was 93. Findings include: Review of the medical record for Resident #83 revealed an admission date of 11/07/19. Diagnoses included traumatic brain injury, schizoaffective disorder, chronic obstructive pulmonary disease (COPD), dementia, alcohol use, depression, cocaine abuse and tobacco use. Review of the smoking evaluation dated 06/06/25 revealed Resident #83 required supervision for smoking. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 was cognitively intact. He was independent in all activities of daily living and functional abilities. Review of the care plan dated 07/17/25 revealed Resident #83 was at an increased risk for health issues due to tobacco use. Interventions included educating about the risks associated with smoking, providing smoking cessation, and always providing supervision for smoking. Interview on 08/05/25 at 2:55 P.M. with Licensed Practical Nurse (LPN) #547 revealed Resident #83 could smoke without supervision but was expected to do so at the designated smoke times. She revealed he was non-compliant with this expectation and smoked whenever he chose. Interview on 08/05/25 at 3:15 P.M. with Resident #83 revealed he could smoke whenever he chose, and he did not believe he needed supervision to do so. Interview on 08/06/25 at 9:40 A.M. with Activity Director #508 confirmed Resident #83 was a supervised smoker. Observation on 08/06/25 at 1:59 P.M. revealed Resident #83 was outside smoking in the pavilion. Activities Assistant #507 remained in the pavilion with Resident #83 as well as other residents who were smoking for approximately 20 minutes. No fire blanket or fire extinguisher was observed in the designated smoking area. Interview on 08/06/25 at 2:31 P.M. with Activities Assistant #507 confirmed she had been outside supervising smokers and when she came in she did not ask Resident #83 to come in with her. She confirmed he required supervision for smoking but left without asking him to come inside because he was often noncompliant with the policy. Interview on 08/07/25 at 7:16 A.M. with the Administrator confirmed there was no smoke blanket or fire extinguisher in the smoking pavilion. Review of the facility policy titled Smoking Policy - Residents, dated August 2010, revealed any resident with restricted smoking privileges requiring monitoring would have direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Park Center Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure lab work was obtained as ordered for Resident #5. The affected one (Resident #5) of three residents reviewed for laboratory services. The facility census was 93. Findings include: Review of the medical record for Resident #5 revealed an admission date of 10/18/21. Diagnoses included respiratory failure, kidney failure, dementia, heart failure, schizoaffective disorder, bipolar disorder and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact. He was independent in eating, required supervision or touch assistance for oral and personal hygiene and partial to moderate assistance for showering and toileting. He had no psychosis or delusions. Review of the physician's orders for August 2025 revealed an order for a Depakote level and Hemoglobin A1c to be drawn every six months which began on 06/20/24, and liver function tests (LFT)'s to be drawn every three months which began on 04/09/24. Review of the lab work completed in the last year revealed a Hemoglobin A1c for Resident #5 was completed 12/23/24, a Depakote level was drawn 04/11/25 and LFT's were drawn 04/11/25. Interview on 08/07/25 at 9:37 A.M. with Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON) #510 confirmed labs had not been drawn as ordered for Resident #5. Review of the facility policy titled Labs and Diagnostic Test Results - Clinical Protocol, dated November 2018, revealed the physician would identify and order lab testing based on the residents' diagnostic and monitoring needs and the staff would process test requisitions and arrange for tests and lab results.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Park Center Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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, observation, staff interview and facility policy review, the facility failed to ensure Resident #80's medical record was accurate to reflect the refusal of the right-hand splint. This affected one (Resident #80) of three residents reviewed for split use. The facility census was 93. Findings include: Review of the medical record for Resident #80 revealed an admission date of 11/08/19. Diagnoses included Alzheimer's disease, stroke affecting the right dominant side, diabetes, right hand contracture, depression, arthritis and muscle weakness. Review of the care plan dated 05/08/25 revealed Resident #80 was at risk for contractures. Interventions included administering pain medication as ordered, encouraging and assisting with repositioning as needed, and reporting nonverbal expressions of pain such as moaning, grimacing, crying or thrashing. The care plan did not include anything regarding the physician's order for the right hand splint. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 was moderately cognitively impaired. He required setup help for eating, supervision for oral and personal hygiene, partial assistance for showering, and substantial or maximum assistance for toileting. He had functional limitations in range of motion to upper and lower extremities on one side. Review of the physician's orders for August 2025 revealed Resident #80 was to wear a right hand splint during the day with it being removed at night for effective contracture management. The order began 12/01/21. Review of the Treatment Administration Record (TAR) for July 2025 revealed the splint was documented as applied to Resident #80's right hand each day and removed each night. There was no documented evidence of refusals. Observation on 08/04/25 at 9:22 A.M. revealed Resident #80 was lying in bed with his right hand contracted. No splint was observed to be in use. Interview on 08/05/25 at 12:47 P.M. with Registered Nurse (RN) #584 confirmed Resident #80 had a contracture to his right hand. She confirmed he has had it for more than one year. She revealed he used to have a splint but has not had one in at least one year because he refused to use it. Interview on 08/06/25 at 2:48 P.M. with Certified Occupational Therapy Assistant (COTA) #519 revealed Resident #80 was ordered a splint for his right-hand contracture, which would be in his bedroom. Observation at the time of the interview confirmed a right-hand splint in the top drawer of Resident #80's bedside table. Interview on 08/06/25 at 2:51 P.M. with Certified Nurse Aide (CNA) #619 revealed she had no knowledge of the splint in Resident #80's bedside table. She was not aware he was supposed to have one; she had never seen it and had never assisted him in applying it. Interview on 08/06/25 at 2:53 P.M. with CNA #561 and staffing coordinator/CNA #564 revealed CNA #561 was aware Resident #80 had a hand splint in his bedside drawer. CNA #564 said he was not required to wear it all the time and often refused to do so. She confirmed refusals would be documented in the medical record. CNA #564 also revealed if staff had attempted to apply the splint and it was removed by the resident; it would also be noted in the medical record that an attempt had been made but was unsuccessful. Interview on 08/07/25 at 8:09 A.M. with Resident #80 revealed he was sitting up in bed eating breakfast. He confirmed he had used a splint for his hand before, but it was not comfortable, and he would not wear it if asked. He could not confirm if he was consistently offered the use of the splint. Interview on 08/11/25 at 10:46 A.M. with Rehab Director #582 confirmed she was aware Resident #80 had a hand splint but stated he hated it and would not wear it for very long. She confirmed staff should be documenting attempts to apply the splint and resident refusals. She also confirmed the use of the splint should be included in the residents' care plan. Review of the undated facility policy titled Resident Splint Use Policy and Procedure revealed the facility would ensure splints were used according to medical orders and care plans. The use of a splint would be incorporated in the residents' care plan including goals reflecting the purpose of the splint. The care plan team, including therapy and nursing, would review splint use at least quarterly or with significant changes in (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Park Center Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition. Residents had the right to refuse the use of a splint, and refusals would be documented, reported to the nurse and provider and the care plan updated to reflect interventions or education provided.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Park Center Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 record review, observation, interview and facility policy review, the facility failed to utilize enhanced barrier precautions (EBP) during wound care when required. This affected one (Resident #6) of two residents reviewed for EBP. There were eight (Residents #6, #24, #68, #70, #76, #82, #88 and #92) who required EBP. The facility census was 93. Findings include: Review of the medical record for Resident #6 revealed an admission date of 05/28/21 with diagnoses including vascular dementia and diabetes mellitus with hyperglycemia. A wound progress note dated 08/04/25 indicated the resident had a diabetic ulcer to the left lateral foot which began on 05/06/25 and required wound dressing changes three times weekly. Review of Resident #6's physician orders dated 07/07/25 revealed to cleanse the left lateral foot wound with normal saline, paint with betadine (antiseptic solution), apply calcium alginate (a dressing used to help maintain a moist wound environment), then cover with an abdominal dressing and gauze wrap three times weekly and as needed. Observation on 08/06/25 at 11:10 A.M. of wound care for Resident #6 with Assistant Director of Nursing (ADON) #510 revealed an EBP sign posted on Resident #6's door with a supply of personal protective equipment (PPE) including gowns and gloves nearby for staff use. ADON #510 entered the room, set-up the wound supplies on a clean barrier and proceeded to engage in the removal of Resident #6's left foot soiled dressing using gloved hands but did not don a gown for EBP. ADON #510 then cleansed the wound after changing gloves and handwashing but continued to conduct the wound care without wearing a gown for EBP. ADON #510 completed the wound care by applying the ordered clean dressings after again changing gloves and handwashing but did so without wearing a gown for EBP. Interview at the time of the observation with ADON #510 verified a gown was not worn for EBP as required while performing wound care for Resident #6. Review of the facility policy, Enhanced Barrier Precautions, revised December 2024 revealed EBP apply when a resident has a wound. Gloves and a gown are applied prior to performing high contact resident care activity which includes wound care (any skin opening requiring a dressing).		