STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365275	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Vista Nursing and Rehab	1216 5th Ave Youngstown, OH 44504

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the AccuWeather forecast and facility policy review, the facility failed to maintain a comfortable temperature in the facility. This affected six (Residents #3, #15, #18, #55, #64, and #84) and had the potential to affect all residents in the facility. The facility census was 92. Findings include: Review of facilities recent hospital transfers revealed Residents #3 and #18 were sent to the hospital on [DATE] due to heat exhaustion symptoms including lethargy, shortness of breath, dizziness, and weakness. 1. Review of Resident #3's medical record revealed an admission date of 01/31/25. Diagnoses included adult failure to thrive, encephalopathy, atrial fibrillation, chronic obstructive pulmonary disease, major depressive disorder, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had severely impaired cognition and required set up assistance with eating and oral hygiene, supervision or touching assistance with showers, dressing, personal hygiene and bed mobility and required partial to moderate assistance by staff for toileting hygiene. Review of Resident #3's progress notes dated 06/23/25 at 8:45 P.M. revealed the resident had gone outside for an extended period of time with another resident. Further review of Resident #3's progress notes dated 06/23/25 at 11:24 P.M. revealed the resident was sent to a local emergency room due to facility staff indicating how hot the facility was, and the resident had complaints of shortness of breath, feeling dizzy, and unable to catch his breath. Vital signs included blood pressure (BP) 115/88, pulse (P) 84, temperature (T) 98.1 degrees Fahrenheit (F), respirations (R) 20 and oxygen saturation (SpO2) 90 percent (%) on three liters per minute of oxygen. Nursing staff assessed the resident and found lungs were clear to auscultation, the resident was very lethargic with slurred speech. The resident had no complaints of pain. Further review of Resident #3's medical record revealed he returned from the hospital on [DATE] at 3:56 A. M. with no new orders. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #18's medical record revealed an admission date of 10/14/24 with diagnoses including Multiple Sclerosis, anxiety, hypertension, and protein calorie malnutrition. Review of Resident #18's quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. He was independent with eating, oral hygiene and personal hygiene. He required partial to moderate assistance with bed mobility, substantial to maximal assistance with showers, and dressing and was dependent on staff for toileting hygiene. Review of Resident #18's progress notes dated 06/23/25 at 3:00 P.M. from the social worker revealed the resident was observed sleeping soundly in the outdoor gazebo in his wheelchair. They gently woke him up to make sure he was feeling okay. The resident stated he was feeling fine. They offered him and other residents in the gazebo water. Resident #18 declined water. Review of Resident #18's progress notes dated 06/23/25 at 8:10 P.M. revealed the resident asked a Certified Nursing Assistant (CNA) to assist him in from outside stating he was dizzy and lethargic. The resident had been outside most of the day. The resident was noted to be lethargic and slow to respond and was complaining of dizziness. The nurse notified the on-call Nurse Practitioner (NP) regarding the resident and received order to send the resident to the hospital. Review of Resident #18's progress note dated 06/24/25 at 9:05 A.M. revealed the resident returned from the hospital after being assessed for fatigue and dehydration. The resident was given intravenous (IV) fluids while at the hospital and returned with no new orders. Interview on 06/25/25 at 3:45 P.M. with the Administrator revealed the air conditioning system had been broken for approximately a year and they were attempting to get it fixed. They stated there was a generator to be delivered on 06/26/25 as well as two 12-ton air conditioning units. The Administrator confirmed Residents #3 and #18 were sent to the hospital on [DATE] due to heat exhaustion symptoms including lethargy, shortness of breath, dizziness, and weakness. Observations made on 06/25/25 at various times of resident room and hallway temperatures with the Maintenance Director (MD) #801 who verified all temperatures taken revealed at: • 4:51 P.M. room [ROOM NUMBER] was 84.2 degrees Fahrenheit (F) • 4:55 P.M. room [ROOM NUMBER] was 81.5 degrees F • 5:01 P.M. room [ROOM NUMBER] was 83 degrees F • 5:03 P.M. room [ROOM NUMBER] was 86 degrees F (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	• 5:05 P.M. room [ROOM NUMBER] was 84.6 degrees F • 5:07 P.M. room [ROOM NUMBER] was 82.4 degrees F • 5:13 P.M. room [ROOM NUMBER] was 84.4 degrees F • 5:16 P.M. room [ROOM NUMBER] was 81.2 degrees F • 5:18 P.M. Nursing 200 Hall was 81.6 degrees F • 5:23 P.M. room [ROOM NUMBER] was 85 degrees F • 5:25 P.M. room [ROOM NUMBER] was 85 degrees F • 5:29 P.M. room [ROOM NUMBER] was 82.2 degrees F • 5:35 P.M. room [ROOM NUMBER] was 85.5 degrees F • 5:38 P.M. room [ROOM NUMBER] was 83.2 degrees F Interview on 06/25/25 at 4:51 P.M. with Resident #15 revealed she was too hot and wanted to leave her room to get to some place cooler. She was sweating, and her hair was sticking to her face due to how hot she was, and she stated she was dizzy and weak. Interview on 06/25/25 at 4:52 P.M. with Licensed Practical Nurse (LPN) #802 revealed the facility was hot and humid. She stated the air conditioning was not working. LPN #802 stated it was so hot in the facility she was wearing a fan attached to her uniform to cool down. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/25/25 at 5:01 P.M. with Resident #55's husband stated her room was entirely too hot, and the facility needed to do something to fix it. Interview on 06/25/25 at 5:03 P.M. with Resident #64 revealed she was very hot and uncomfortable. Her room was 86 degrees F. She stated she needed the two fans in their room due to how hot the facility was, and she was very unhappy about it. Interview on 06/25/25 at 5:09 P.M. with CNA #808 revealed the facility was hot and uncomfortable not just for staff but for the residents too. CNA #808 stated they were offering residents water and trying to keep them as cool as possible until the air conditioning was fixed. Interview on 06/25/25 at 5:13 P.M. with Resident #80 revealed his room was too hot and he was uncomfortable. Resident #80's room was 84.4 degrees F. Interview on 06/25/25 at 5:45 P.M. with MD #801 confirmed the facility ordered a total of 15 portable air conditioning units. He was waiting for them to arrive. He confirmed the one heating and air company comes and fixes certain units for the main system, and a third company fixes the issues they are having now. He was unable to provide the names and/or invoices of the second company. MD#801 confirmed no one was onsite to fix the air conditioning problems at the moment, but he was waiting for someone to arrive. MD #801 confirmed the residents' rooms were not at the appropriate temperatures. Review of AccuWeather.com revealed the outdoor temperatures included: • 06/21/25 was a high of 87 degrees F. • 06/22/25 was a high of 92 degrees F. • 06/23/25 was a high of 93 degrees F. • 06/24/25 was a high of 94 degrees F. • 06/25/25 was a high of 90 degrees F. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Emergency Preparedness Policy, dated 10/10/17, revealed in the event that there is a loss of function in the cooling system or there is an area in the facility that the system has failed during hot weather, the following procedures should be implemented when the facility temperature reaches 81 degrees F and remains for greater than four hours, set up fans and portable air conditioners, draw all shades, remove residents from direct sunlight, provide ample fluids, and contact the medical director. Central air coolers are maintained at a comfortable temperature range generally between 72-78 degrees F. This deficiency represents non-compliance investigated under Master Complaint Number OH00166949.

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F 0921 Level of Harm - Minimal harm or potential for actual 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** Based on observation, invoice review and interview, the facility failed to ensure the dishwasher was in good working condition. The facility has served all meals since 05/09/25 on paper products with plastic silverware when the dishwasher broke. This affected 90 of 92 residents residing in the facility. Residents #8 and #88 did not receive food from the kitchen. The facility census was 92. Findings include: Observation on 06/25/25 at 4:23 P.M. of residents eating dinner in the dining room and in residents' rooms revealed they were being served on paper plates with plastic silverware. Observation of the dishwasher on 06/26/25 at 1:00 P.M. revealed it was broken and not in working order. Interview on 06/26/25 at 1:15 P.M. with Maintenance Director (MD) #801 confirmed the dishwasher had a power surge that caused it to stop functioning. He reported the delay in getting it fixed was ordering parts and scheduling of the maintenance service. Interview on 06/26/25 at 1:18 P.M. with the Administrator revealed they confirmed the dishwasher had been broken since 05/09/25 after a power surge. The Administrator stated they had a company come out to fix it and they needed to order parts. The Administrator stated the company was to return to the facility on [DATE] to repair the dishwasher. Interview on 06/30/25 at 2:05 P.M. with the Administrator revealed the repair company did come to the facility on [DATE] but were unable to fix the dishwasher due to the additional parts needed. Interview on 06/30/25 at 2:10 P.M. with the Dietary Manager (DM) #810 revealed they confirmed residents have been served on paper plates with plastic silverware for the past six weeks. They reported that the dishwasher had a power surge, and it still was not working. DM #810 confirmed all adaptive devices were still used per order and were washed, rinsed and sanitized using the three-bay sink system in the kitchen after every meal. Review of the invoices for the dishwasher revealed that the machine went down on 05/09/25. Repairs were not made until 06/20/25, and new parts were ordered on 06/23/25. The machine was still not functional. This deficiency was an incidental finding identified during the complaint investigation.