

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure residents were offered showers on a consistent basis. This affected two residents (Residents #48 and #59) of five residents reviewed for activities of daily living (ADL) assistance. The facility identified 75 Residents (#2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, 19, #20, #21 #22, #23, #24, #25, #26, #27, #28, #29, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55 #56, #57, #58, #59, #60, #61, #62, #63, #65, #67, #68, #69, #70, #71, #72, #73, #74 #92, #94, #95, #96 and #97) as needing assistance with showers. The facility census was 94. Findings include: 1. Review of the medical record for Resident #48 revealed an admission date of 10/27/25. Diagnoses included left femur fracture, heart disease, history of falling, hypertension, kidney disease and dementia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 was severely cognitively impaired. He required set up help for eating, supervision for oral hygiene, substantial to maximum assistance for showers and was dependent on staff for toileting. Review of the care plan dated 01/06/26 revealed Resident #48 had an ADL performance deficit due to weakness. Interventions included assisting the resident in showering or bathing with substantial or maximum assistance. Review of the facility certified nurse aid (CNA) tasks in the electronic medical record (EMR) revealed Resident #48 was to receive a shower twice a week, on Mondays and Thursdays. Review of the shower sheets for Resident #48 for November and December 2025 revealed he received a shower on 12/26/25 and a bed bath on 11/07/25, 11/13/25, 11/17/25, 11/27/25, 12/01/25, 12/11/25, 12/18/25 and 12/22/25. He refused a shower on 11/05/25, 12/15/25 and 12/29/25. 2. Review of the medical record for Resident #59 revealed an admission date of 09/19/24. Diagnoses included diabetes chronic bronchitis, hyperlipidemia and sleep apnea. Review of the care plan dated 12/16/25 revealed Resident #59 had an ADL performance deficit due to weakness. Interventions included assisting the resident in showering or bathing with substantial or maximum assistance. Review of the quarterly MDS assessment dated [DATE] revealed Resident #59 was cognitively intact. He was independent in eating, required set up help for oral hygiene, substantial to maximum assistance for showers and was dependent on staff for toileting. Review of the facility CNA tasks in the EMR revealed Resident #59 was to receive a shower twice a week, on Thursdays and Saturdays. Review of the shower sheets for Resident #59 for November and December 2025 revealed he received a shower on 11/27/25 and a bed bath on 11/01/25, 11/06/25, 11/08/25, 11/15/25, 12/11/25 and 12/27/25. He refused a shower on 11/20/25, 12/04/25, 12/06/25, 12/13/25, 12/20/25, 12/23/25, and 12/25/25. Interview on 01/07/26 at 9:02 A.M. with Resident #59 revealed he is never offered a shower. Interview on 01/07/25 at 9:40 A.M. with CNA #202 revealed if a resident refused a shower a bed bath would be offered instead. Interview on 01/14/25 at 8:20 A.M. with the Administrator confirmed showers, bed baths and refusals were not consistently provided to or documented for Residents #48 and #59. Review of the facility policy titled Bathing,</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 365275	If continuation sheet Page 1 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>dated January 2020, revealed the facility would promote cleanliness and comfort to the resident by honoring bathing preferences and giving showers twice per week. If a resident refused, documentation would occur and the nurse would be notified. This deficiency represents noncompliance investigated under Complaint Numbers 2667441 and 2639314.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(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** Based on record review, observation and interview, the facility failed to implement timely treatment for skin breakdown for Resident #59 and failed to ensure treatments were completed as ordered for Resident #90. This affected two residents (#59 and #90) of three residents reviewed for skin care. The facility census was 97. Findings include: 1. A record review for Resident #59 revealed an admission date of review of the medical record for Resident #59 revealed an original admission date of 09/23/25 diagnoses included diabetes with neuropathy, hypertension, and chronic obstructive pulmonary disease. A review of Resident #59 Minimum Data Set (MDS) assessment dated [DATE] and a quarterly assessment dated [DATE] revealed that Resident #59 was alert, and oriented without memory impairment. Resident #59 required maximum assistance to total dependence on staff for performance of activities of daily living (ADL). Resident #59 required a total mechanical lift for transfer and a manual wheelchair. A review of the physician's orders for Resident #59 revealed an order dated 11/30/25 to cleanse his right flank with normal saline, apply Adaptec and a dry dressing daily and as needed. A review of the progress notes for Resident #59 revealed a note dated 01/02/26 authored by Registered Nurse (RN) #205 that stated Resident #59 had a new area of impaired skin integrity to his left flank and that the wound care nurse had been notified of the new area. There was no evidence that the physician or responsible party were notified, and no documented evidence that a treatment was implemented. An interview on 01/08/25 at 10:30 A.M. with Resident #59 revealed that he had reported discomfort to his left flank and that RN #205 had looked at it on 01/02/26, but that no one had done a dressing to that area. An observation of wound care with Wound Care Nurse #217 and Licensed Practical Nurse (LPN) #203 for Resident #59 on 01/08/25 at 1:55 P.M. revealed a new area on Resident #59 left flank. The area was red and approximately 2.0 centimeters (cm) by 2.0 cm by no depth in between skin folds. The area was assessed by Wound Care Nurse #217 and identified as a non-pressure area of moisture associated skin damage (MASD). An interview on 01/08/25 at 2:05 P.M. with Wound Care Nurse #217 revealed that it was possible that RN #205 had notified her of the new skin impairment. The usual method of communication was either a phone call or via text message. Wound Care Nurse #217 had been off the prior five days and had just returned to work that morning. Wound Care Nurse #217 verified that there was no order for Resident #59 left flank. Further it was revealed that Wound Care Nurse #217 would expect that the nurse on duty would notify the wound care nurse, the Director of Nursing (DON), the provider and the family. The nurse was expected to obtain new orders to treat any new area of skin impairment. An interview with LPN #203 on 01/13/26 at 8:58 A.M. revealed that when a new area of impaired skin integrity was identified the nurse would notify the provider to obtain new orders and that the wound care nurse was notified of all new skin issues for further assessment. 2. A review of the medical record for Resident #90 revealed an admission date of 10/10/25. Diagnoses included peripheral vascular disease, and chronic ulcer of the left lower leg and ankle. A review of the facility grievance log revealed a family concern dated 10/18/25 related to wound care for Resident #90's treatments were not being completed as ordered. The concern was investigated by the Director of Nursing and an employee was disciplined. A review of the five-day MDS assessment dated [DATE] revealed that Resident #90 was alert and oriented without cognitive deficit. Resident #90 was independent for eating, required minimal staff assistance for ADL that involved the upper extremities and maximum assistance for the lower extremities. A review of the physician's orders for Resident #90 revealed an order dated 10/01/25 and discontinued 11/09/25 to cleanse the left lower leg (vascular ulcer), apply calcium alginate, and cover with a dry dressing daily; an order dated 12/05/25 and discontinued 12/17/25 to cleanse the left foot with normal</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(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>saline, apply gentamicin ointment (antibiotic), calcium alginate, cover with an abdominal pad (ABD) and wrap with Kling gauze daily and as needed.A review of the treatment administration records (TAR) for Resident #90 revealed for October and November 2025 the treatment for Resident #90's left lower leg due daily at 7:00 A.M. was not completed on 10/14/25, 10/16/25, 10/17/25, 11/04/25, 11/05/25, and 11/06/25.A further review of the TAR for Resident #90 for December 2025 revealed that the treatment for Resident #90 left foot due at 7:00 A.M. daily was not completed on 12/05/25, 12/10/25, and 12/17/25A review of the progress notes from October through December 2025 for Resident #90 revealed no documented evidence to explain why wound care was not completed for October, November or December dates.An interview on 01/14/25 at 1:00 P.M. with the Director of Nursing verified that the treatments were not documented as not completed. His expectation was that wound care be completed as ordered. If a nurse was unable to complete any ordered procedure, he expected the nurse to communicate with their supervisor and to pass along any uncompleted work to the next shift to ensure that the residents received their care. It was further revealed that he had disciplined LPN #221 and had terminated her for poor work performance which included not doing wound treatments for Resident #90. LPN #221 was terminated on 10/31/25. Staff education was initiated 01/14/25 related to wound care policy and procedure.This deficiency represents noncompliance investigated under Complaint Number 2639314.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of hospital records, review of a facility investigation, review of an emergency medical service (EMS) run report, review of the time and date weather historical data, facility policy review, and interview, the facility failed to ensure adequate supervision and monitoring to prevent hospitalization for hypothermia for Resident #66. In addition, the facility failed to ensure fall interventions were in place for Resident #48. This affected two residents (#66 and #48) of three reviewed for accidents. The facility census was 94. Actual Harm occurred on 12/30/25 when the facility failed to provide adequate supervision and implement appropriate and effective interventions to mitigate known risk for Resident #66 who was found unresponsive outdoors, after being outside for an unknown amount of time and was subsequently hospitalized and treated for hypothermia. Resident #66 had known behaviors related to staying outside for long periods of time and a prior hospitalization for hypothermia on 02/07/25 while the resident resided in the facility's attached assisted living. Despite the known behavior, Resident #66 was to receive routine every (Q) two-hour staff monitoring, the facility standard for all residents even when outside, including on 12/30/25 when the temperature was a high of 19 degrees Fahrenheit (F) and a low of 18 degrees F. Findings include: 1. Review of the medical record for Resident #66 revealed an admission date of 12/04/25 with diagnoses including respiratory failure, hypertension, chronic obstructive pulmonary disease (COPD), kidney disease, arthritis and tobacco use.</p> <p>Review of the resident history revealed prior to admission to the skilled nursing facility, Resident #66 resided in the facility attached residential care facility. Record review revealed on 02/07/25 the resident had been hospitalized and treated for hypothermia after being outside in inclement weather for an extended period of time.</p> <p>Review of the care plan dated 12/05/25 revealed Resident #66 had a behavior problem of refusing treatment and oxygen and staying outside for long periods of time. Interventions included educating on the risks of using his motorized wheelchair without charging it, offering choices, providing emotional support and reassurance as needed and keeping his schedule routine and predictable. Record review revealed there was no plan of care developed with comprehensive/individualized interventions for the resident's safety risk/supervision when outside or to address safety needs related to the resident's desire to stay outside for long periods of time.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was cognitively intact. The assessment revealed the resident required (staff) supervision for eating and personal hygiene and partial to moderate assistance for oral care, toileting and showering.</p> <p>Review of a psychotherapy progress note dated 12/10/25 revealed Resident #66 was outside smoking a cigarette at the time of the interview. Resident #66 had minimal eye contact and denied all mental health symptoms and concerns. The note included the resident became agitated and argumentative with further attempts to explore potential symptoms of mental health related concerns.</p> <p>Review of a nursing progress note dated 12/30/25 at 2:59 P.M. revealed Resident #66 was assessed by the nurse. The note included neck and abdomen wounds remain resolved. Epithelial tissue present and intact. This nurse to follow- up as needed (PRN). Resident #66 was updated and aware. Nurse Practitioner (NP) #216 aware of wound resolutions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>There were no further nursing progress notes until 12/30/25 at 10:34 P.M. when Resident #66 was found unresponsive in the smoke room.</p> <p>Review of a nursing progress note dated 12/30/25 at 10:34 P.M. revealed Resident #66 was found in the smoke room unresponsive. Oxygen was applied, and 911 was called. Upon EMS arrival, Resident #66's pupils were pinpoint and he was administered Narcan (used to reverse an opioid overdose) and was unable to communicate. The resident was taken to the local emergency department (ED). (A hospital drug screen revealed the resident only had Acetaminophen in his system).</p> <p>Review of weather information at https://www.timeanddate.com/weather/usa/youngstown/historic dated 12/30/25 revealed the temperature was a high of 19 degrees F and a low of 18 degrees F from 6:00 P.M. through 12:00 A.M. with light snow, mostly cloudy, humidity 82%</p> <p>Review of an EMS emergency response report dated 12/30/25 at 10:06 P.M. revealed Resident #66 was found slumped over in his wheelchair outside of the facility. The nurses reported he had been outside for an unknown amount of time. Upon assessment, the resident was responsive to painful stimuli and muttered sounds. His breathing was slow and shallow, and he had bradycardic peripheral pulses. His pupils were pinpoint and non-reactive. The resident was administered Narcan and became more responsive with improved breathing but remained confused and muttering words. He was able to follow commands. He was very cold to the touch and EMS records included they were unable to get an accurate temperature reading. He was warmed with blankets and heat packs, and his vitals became stable and within normal limits. Intravenous medications could not be administered because of poor blood flow, and an electronic cardiogram could not be performed because the electrodes would not stick to the resident. Resident #66 became increasingly responsive but remained confused while being transported to the local emergency room.</p> <p>Review of the emergency department report dated 12/30/25 at 10:44 P.M. revealed Resident #66 was brought to the facility for altered mental status. Vital signs upon arrival included blood pressure 149/88 and pulse 44. The hospital record included an entry on 12/31/25 at 2:16 A.M. of the resident's temperature being 83.3 degrees F. An entry on 12/31/25 at 6:43 A.M. included the resident's temperature was 85.1 degrees F. A central line was inserted, and the resident was admitted to the hospital.</p> <p>Review of the health status note dated 12/31/25 at 6:54 A.M. revealed Resident #66 was admitted to critical care on a ventilator with altered mental status, low oxygen levels and hypothermia. As of 01/15/26 the resident remained hospitalized .</p> <p>Review of an undated facility investigation revealed Resident #66 was seen by the wound nurse at approximately 3:00 P.M. on 12/30/25. Resident #65 was reported as seeing Resident #66 and the outdoor smoke room between 4:30 P.M. and 5:00 P.M. Resident #66 was found on 12/30/25 at 10:34 P.M. in the smoke room unable to respond, and 911 was called. The investigation further included staff working at the time of the incident were interviewed and no one reported seeing Resident #66 prior to RN #215 finding him unresponsive, when she had taken a smoke break. Resident #65 reported he had seen Resident #66 before dinner around 4:30 P.M. to 5:00 PM. He revealed he was aware Resident #66 liked to spend a lot of time in the smoke room and at times would fall asleep in the room. He reported no concerns of note when he last saw Resident #66. Camera footage of the front door was reviewed on 12/31/25. On 12/30/25 from 5:00 P.M. until 10:00 P.M. Resident #66 was not seen on the camera footage and the smoke room was not visible from the outside camera view. Review of the facility investigation revealed there were no actual written statements from staff working and/or with knowledge of the incident. In addition, the facility written investigation failed to include what the resident was wearing at</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>the time he was found or what the temperature of the outdoor smoke area was at the time the resident was found unresponsive.</p> <p>Interview on 01/07/26 at 10:47 A.M. with the Administrator revealed Resident #66 had a known history of always wanting to be outside, regardless of the weather. The Administrator revealed the resident would often leave the facility in his power wheelchair which would run out of battery power. He would call the facility to pick him up.</p> <p>Interview on 01/07/26 at 11:42 A.M. with the Director of Nursing (DON) revealed Resident #66 would often sit outside for hours but stated he was checked on routinely. The DON revealed the resident was found on 12/30/25 not at his baseline at which point EMS was called and he was given Narcan, which was standard protocol for the area when a resident was unresponsive. The DON confirmed Resident #66 was lethargic and wouldn't speak. The DON verified it was cold outside at the time, but stated Resident #66 often chose to be outside and did not like the indoor smoking [NAME]. He revealed the resident was usually appropriately dressed for the weather, wearing a hat, gloves and appropriate footwear.</p> <p>Interview on 01/08/26 at 7:34 A.M. with Medical Director (MD) #206 revealed Resident #66 could make his own decisions but often did not make good choices. While at the hospital he was referred to a psychiatrist and was really not interested in services. Often when she came to see the resident, she had to look for him outside or in the lobby because he was almost never in his room. MD #206 stated she believed the resident was outside for approximately three to four hours before he was found on 12/30/25, which she stated was normal for him.</p> <p>Interview on 01/08/26 at 2:04 P.M. with Licensed Practical Nurse (LPN) #214 revealed on 12/30/25 she was told by Registered Nurse (RN) #215 that Resident #66 was outside and not responding. LPN #214 obtained the resident's oxygen and placed it on him, and he responded slightly while she called 911. The LPN revealed the resident was wearing gloves and a hoodie at the time of the incident but could not recall if he was wearing a jacket.</p> <p>Interview on 01/12/26 at 7:14 A.M. with the Administrator revealed being that staff were familiar with Resident #66 and his desire to be outside, they checked on him every one to two hours. She revealed two-hour checks were the standard of care for all residents and the facility had not considered implementing more frequent checks for Resident #66. Record review revealed there was no documentation of any checks for Resident #66 being completed.</p> <p>Observation on 01/13/26 at 7:43 A.M. with the DON revealed the facility had a smoke room attached to the facility which was fully enclosed and heated. The DON could not confirm whether Resident #66 was in the smoke room or outside when EMS arrived.</p> <p>On 01/15/26 at 4:35 P.M. information provided from the Administrator via email verified the resident's care plan did not include a frequency of monitoring/checks for safety/supervision.</p> <p>Review of the facility policy titled Resident Supervision, dated 10/22/25, revealed the facility would provide sufficient supervision to meet the resident's assessed needs while respecting the right to informed choices. Residents who demonstrated decision making capacity could be granted decreased supervision if the demonstrated the ability to make informed decisions, had a Brief Interview for Mental Status (BIMS) score of 12 or greater and were their own responsible party. Residents with decreased supervision would accept and acknowledge reasonable risk associated with independent</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>decision-making including risks related to weather exposure and smoking. The facility would provide education regarding risks while honoring resident rights and levels of supervision would be included in the care plan and revised with any change in condition.</p> <p>2. Review of the medical record for Resident #48 revealed an original admission date of 09/23/25 from the assisted living unit on campus due to falls. Diagnoses included dementia, cognitive communication deficit, and heart failure. Resident #48 was discharged [DATE] to an acute care hospital with return anticipated after a fall. Resident #48 returned to the facility 11/01/25. Diagnoses for hospitalization left femoral neck fracture after a fall.</p> <p>Review of fall risk assessment revealed that the admission fall risk assessment dated [DATE] revealed Resident #48's fall risk was low.</p> <p>Review of the care plan initiated on 09/24/25 and revised on 10/01/25 revealed Resident #48 was to have the call light within reach (initiated on 09/24/25), physical therapy and occupational therapy to evaluate and treat as ordered (initiated on 09/24/25), keep room free of clutter (initiated on 10/01/25), a visual reminder to call for assistance (initiated on 10/22/25), bilateral floor mats one to each side of his bed (initiated on 11/06/25), and a defined perimeter mattress (initiated on 11/10/25).</p> <p>Review of the admission MDS assessment dated [DATE] and the quarterly MDS assessment dated [DATE] Resident #48 was severely cognitively impaired and dependent upon staff for all activities of daily living (ADL) except for eating.</p> <p>Review of the fall risk assessment dated [DATE] revealed Resident #48's fall risk was high.</p> <p>Review of Resident #48 progress notes and fall investigations revealed Resident #48 fell on [DATE], 11/02/25, and 11/09/25. Neuro checks were completed, immediate interventions were put in place, fall risks, interventions and care plans were reviewed by the interdisciplinary team after each fall.</p> <p>An observation on 01/14/26 at 12:32 P.M. of Resident #48 revealed him lying in bed on his left side, and the call light was within reach. A visual cue was noted on his bulletin board; a defined perimeter mattress was on his bed; there was a floor mat to the left side of the bed, and the other floor mat was propped against a wall behind the empty bed across the room from Resident #48.</p> <p>Interview on 01/14/26 at the time of the observation with Certified Nursing Assistant (CNA) #218 verified the floor mat was not in place as ordered.</p> <p>This deficiency represents noncompliance investigated under Complaint Numbers 2709253, 2667441, and 2639314.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, record review, interview and facility policy review, the facility failed to serve palatable meals, and ensure meals were served in a manner that prevented possible contamination. This affected eight residents (Residents #22, #25, #28, #57, #63, #72, #73, #80 and #84) of eight reviewed for food quality, palatability and service, and had the potential to affect all 94 residents in the facility with the exception of Residents #19, #87 and #91, who did not receive meals by mouth. Findings include: Review of the medial record for Resident #22 revealed an admission date of 07/18/24. Diagnoses included difficulty walking, muscle weakness and protein calorie malnutrition. Review of the medial record for Resident #25 revealed an admission date of 01/17/25. Diagnoses included diabetes, high cholesterol, history of stroke and depression. Review of the medial record for Resident #28 revealed an admission date of 10/02/24. Diagnoses included heart disease, high cholesterol, diabetes and history of stroke. Review of the medial record for Resident #57 revealed an admission date of 09/27/25. Diagnoses included respiratory failure, kidney disorder, anemia, high cholesterol and alcohol abuse. Review of the medial record for Resident #63 revealed an admission date of 10/02/24. Diagnoses included Parkinson's, sleep apnea, high cholesterol and depression. Review of the medial record for Resident #72 revealed an admission date of 12/16/25. Diagnoses included heart failure, diabetes, sleep apnea, carpal tunnel and psychoactive substance abuse. Review of the medial record for Resident #73 revealed an admission date of 11/06/25. Diagnoses included high cholesterol, high blood pressure, alcohol dependence, muscle weakness and depression. Review of the medial record for Resident #80 revealed an admission date of 12/09/25 and a discharge date of 01/09/26. Diagnoses included repeated falls, diabetes, depression, muscle weakness and cellulitis. Review of the medial record for Resident #84 revealed an admission date of 10/22/25. Diagnoses included diabetes, hypertension, chronic pain, morbid obesity, depression and muscle weakness. Review of the Resident Council minutes for November and December 2025 revealed resident concerns regarding food being served cold. Interview on 01/07/26 at 9:02 A.M. with Residents #28 and #84 revealed meals were never warm when they received them, and Resident #28 revealed she had not had a hot meal in months. Resident #80 additionally reported meals were usually served in Styrofoam take-out containers. Interview on 01/07/26 at 11:38 A.M. with Stepping-Stones Counselor #207 revealed she often had to heat meals up for residents when they brought them to a group session because the food was usually served cold. Interview on 01/07/26 at 1:16 P.M. with Resident #80 revealed the food was often served cold, and he was tired of eating out of Styrofoam containers. He reported today was the first day they had received their meals on regular plates since he was admitted. Interview on 01/08/26 at 11:45 A.M. with Dietary Manager #210 revealed trays were normally passed to all residents within one hour and 15 minutes to one hour and 20 minutes. She admitted there were times the facility had to use Styrofoam containers when the dish machine needed repair. She revealed they had last been used approximately two weeks ago for two to three weeks. Interviews on 01/12/26 from 1:15 P.M. through 1:37 P.M. with Residents #22, #25, #57, #63 and #72 confirmed meals were often served cold, did not taste good and were often served in Styrofoam containers. Observation of tray line on 01/08/26 at 11:45 A.M. revealed lunch consisted of tomato soup, cold ham and cheese sandwiches and sweet potato fries. Temperatures were obtained prior to meal service, and the soup temperature was 206.9 degrees Fahrenheit (F), sweet potato fries 187 degrees F, and the ham and cheese sandwiches 44.3 degrees F. [NAME] #209 was observed using a gloved hand to retrieve hamburger buns and slices of cheese from containers. She did not change her gloves or wash her hands before resuming other tray line tasks. Interview at the time of the observation with [NAME] #209 confirmed she had not changed her gloves or practiced infection control measures when preparing sandwiches.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Park Vista Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>As meal service continued, additional sweet potato fries were retrieved from the oven and appeared black on the ends. Interview with [NAME] #208 at the time of the observation confirmed the sweet potato fries had been burnt. [NAME] #208 ran out of soup bowls prior to the end of tray line for approximately five to six residents and had to wait approximately 10 minutes for the dishwasher to wash bowls in order to resume tray line. [NAME] #208 confirmed they often did not have enough dishes for each meal service and had to wash breakfast dishes in order to have enough for lunch, and there were still times they ran short. She also confirmed she had used the last of the tomato soup and the remaining five to six residents were given chicken noodle soup as a replacement. The last tray left the kitchen at 1:17 P.M. and the last resident was served at 1:22 P.M. A test tray was obtained and temperatures taken. The chicken noodle soup reached temperature of 146 degrees F, the sweet potato fries were 81 degrees F, and the sandwich was 60 degrees F. Dietary Manager #210 confirmed hot food should be at a temperature of 135 degrees F by the time the resident received it and cold temperatures should be between 40- and 55-degrees F. She confirmed the sweet potato fries were cold, soggy and burnt, and the sandwich was not an appropriate temperature for meal service. Interview on 01/14/26 at 8:11 A.M. with the Administrator confirmed the facility was aware of issues residents had regarding meals being cold upon delivery. Review of the facility policy titled Food and Nutrition Services, dated October 2017, revealed each resident would be provided with a nourishing, palatable well balanced diet ensuring meals were provided within 45 minutes of either resident request or scheduled mealtime. Food and nutrition services staff would inspect food trays to ensure the correct meal was provided to each resident, food appeared palatable and attractive and was served at a safe and appetizing temperature. This deficiency represents noncompliance investigated under Master Complaint Number 2709374 and Complaint Number 2639314.</p>		