STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365766	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Health Care Center	930 East Park Avenue Columbiana, OH 44408

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 record review, interview and review of facility policy, the facility failed to treat residents with dignity and respect. This affected one resident (#224) of four residents reviewed for dignity. The facility census was 68.Findings include:Review of the medical record for Resident #224 revealed an admission date of 06/17/22. Diagnoses included hypertensive heart disease with chronic kidney disease, infectious gastroenteritis, type two diabetes mellitus with diabetic neuropathy, chronic kidney disease stage four, permanent atrial fibrillation, gout and end state renal disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 on a 0-15 scale. A BIMS score of 15 would indicate the resident was cognitively intact. The MDS indicated the resident used a wheelchair for transportation, and was dependent on staff for transfers, bathing and toileting. Review of a care plan for Resident #224, initiated on 06/29/23 and revised 07/21/25, revealed a focus of care for person centered care. This focus of care revealed the resident required two person assist for bed mobility, one person assist for grooming/hygiene, two person assist for toileting and Hoyer lift for transfers. There was a focus of care for self care deficit, which included an intervention to turn and reposition the resident every two hours. The care plan focus for Resident #224 initiated 09/23/25 revealed a potential for pressure ulcer development. Interventions included encouraging and assisting the resident to turn and reposition every two hours while in bed, and to follow facility policies and protocols for prevention/treatment of skin breakdown. The interventions also indicated the staff should encourage/educate the resident regarding the importance of changing positions every two hours and as needed for the prevention of pressure ulcers. Review of a Self Reported Incident (SRI) 267673 dated 11/17/25 revealed Resident #224 reported verbal abuse to the Administrator. She reported Certified Nurse Aide (CNA) #819 had told her she could poop her pants like everyone else here when the resident asked for assistance to the toilet. The resident had been having diarrhea and after assisting to the toilet the CNA allegedly told the resident she had been making up having diarrhea so she would be taken to the restroom first. The statement by the Administrator indicated the resident told her CNA #819 was always mean to her and called her a liar. The investigation included a statement, dated 11/18/25, from CNA #819 revealed she made a statement to the resident I never said your name at all in my conversation with [CNA #657], and do not put words in my conversation with [CNA #657] saying I was talking about her. I said I never said her name and don't accuse me of saying anything about her. On 05/13/26 at 12:38 P.M., an interview with Licensed Practical Nurse (LPN) #439 revealed CNA #819 would get easily overwhelmed. When she did, she would become very short with both residents and staff. On 05/13/26 at 1:41 P.M., an interview with CNA #657 revealed she could not recall the conversation in the bathroom between Resident #224 and CNA #819. She did recall CNA #819 was rude with everyone and was just not a friendly person. She recalled CNA #819 and Resident #224 had back and forthes a few times. On 05/13/26 at 2:14 P.M., an interview with Resident #224 revealed she had multiple incidents where CNA #819 was rude to her and called her a liar. When she had to take an antinausea medication prior to showering after a hospitalization, a nurse (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
	365766	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Health Care Center	930 East Park Avenue Columbiana, OH 44408

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	had advised her to wait a half hour before showering and she should have relief. CNA #819 came immediately into her room and told her it was now or never to get her shower. She explained she had just been medicated, however the aide told her she did not care and did not have time. When she had an incident of diarrhea, the aide called her a liar. Told her she just needed to poop her pants, then, and they would have to change her like everyone else around here. She indicated CNA #819 had talked like this to her all of the time, and finally she got tired of it and reported it to the Administrator. The resident reported the interactions with the aide made her feel terrible and sad. On 05/13/26 at 4:20 P.M., an interview with CNA #704 revealed she was aware Resident #224 and CNA #819 would butt heads. She did not like how CNA #819 talked with people, and she was like that with everyone. She did note, however, that CNA #819 was especially rude to Resident #224. Review of a facility policy titled Dignity, Respect, and Privacy, revised 05/2024, revealed all residents in the facility would be treated with kindness, dignity, and respected whenever talked with, cared for, or talked about. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2687730.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365766	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Health Care Center	930 East Park Avenue Columbiana, OH 44408

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **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 call lights were within reach of residents to allow them to notify staff of the need for assistance. This affected two residents (#221, #273) of four residents reviewed for call lights. The facility census was 68.Findings include:1.Review of the medical record for Resident #221 revealed an admission date of 07/23/24. Diagnoses included Parkinson's disease without dyskinesia, repeated falls, insomnia, other symbolic dysfunctions, need for assistance with personal care, dysphagia, chronic kidney disease stage three, major depressive disorder, psychotic disorder with delusions, psychotic disorder with hallucinations, and Alzheimer's disease. Review of a quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four on a 0-15 scale. A BIMS score of 4 would indicate severe problems with thinking and memory. The MDS also indicated the resident had behaviors which included physical behavioral symptoms directed towards others such as hitting, kicking, pushing, scratching, grabbing and abusing others, as well as threatening, screaming or cursing at others. Further the resident had behaviors directed at herself such as hitting or scratching herself, pacing, rummaging, screaming and/or disruptive sounds. Review of a care plan initiated 11/22/23 and revised 03/26/26 revealed a person centered plan of care with interventions that included a bed pad or chair alarm to alert staff of unassisted transfers, an assist of two for bathing and bed mobility, incontinence of bowel and bladder, and confusion. She required two assists for toileting and transfers with a Hoyer Lift. She had interventions in place to remind the resident to use the call light and ask for assistance to prevent falls. There was a focus of care for incontinence of bladder. Interventions included checking and changing the resident every two hours and as needed, incontinence care, responding to resident's request to toilet or sign of distress as quickly as possible, and ensuring the call light was within reach. On 05/13/26 at 2:05 P.M., an observation of Resident #221 revealed she was in her wheelchair near her bed. Her call light was over the back of her recliner on the other side of her room. This observation was confirmed by Licensed Practical Nurse (LPN) #439 on 05/13/26 at 2:08 P.M. On 05/13/26 at 4:54 P.M., an interview with LPN #439 revealed the facility did not have an alternative system to use for residents who were not able to effectively use a call light or call pad system. She thought the best thing to do would be to have increased checking in place for the resident. 2. Review of the medical record for Resident #273 revealed he was admitted to the facility on [DATE]. His initial care plans and MDS were being developed. The resident was admitted with diagnoses that included sepsis, difficulty in walking, muscle weakness, need for assistance with personal care, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, unspecified severe protein-calorie malnutrition, metabolic encephalopathy and malignant neoplasm of upper right lung. On 05/13/26 at 2:27 P.M., an observation of Resident #273 revealed he was lying in bed sleeping soundly. His call light was wrapped around the arm of his wheelchair and out of his reach. This observation was confirmed by Certified Nurse Aide (CNA) #657 on 05/13/26 at 2:29 P.M. On 05/13/26 at 2:29 P.M., CNA #657 confirmed the call light for Resident #273 was out of his reach and wrapped around the arm of his wheelchair while he was lying in bed. She removed the call light and placed it near the resident and explained to him where it was located. Review of a facility policy titled Call Lights, Use of, revised 02/2026, revealed the facility would respond in a timely manner to resident's call for assistance. The policy listed equipment as a bedside call light in functioning order and an emergency call light in functioning order, ensuring the resident could reach the call light or cord even if lying on the floor. All facility personnel were to be aware of call lights at all times. The resident should never feel as if the staff were too busy to provide assistance, or offer further assistance before staff left the resident room. When care was provided to the resident, the call light should be placed in a position convenient for the resident to use. The staff should tell the resident where the call light was and show the resident how to use the call light. All new residents (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365766	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Health Care Center	930 East Park Avenue Columbiana, OH 44408

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were to be oriented to the call light at the bedside. The quality assurance and assessment committee would review any concerns with call light function or response and address any needed systemic changes and audits to attain and maintain compliance. This deficiency represents non-compliance investigated under Complaint Number 2687730.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365766	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Health Care Center	930 East Park Avenue Columbiana, OH 44408

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to thoroughly investigate an incident of alleged verbal abuse. This affected one resident (#224) of four residents reviewed for abuse. The facility census was 68.Findings include:Review of the medical record for Resident #224 revealed an admission date of 06/17/22. Diagnoses included hypertensive heart disease with chronic kidney disease, infectious gastroenteritis, type two diabetes mellitus with diabetic neuropathy, chronic kidney disease stage four, permanent atrial fibrillation, gout and end state renal disease. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #224, dated 10/23/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 on a 0-15 scale. A BIMS score of 15 would indicate the resident was cognitively intact. The MDS indicated the resident used a wheelchair for transportation, and was dependent for transfers, bathing and toileting. Review of a care plan for Resident #224, initiated on 06/24/23 and revised on 07/21/24, revealed a focus of care for person centered care. This focus of care revealed the resident required two person assist for bed mobility, one person assist for grooming/hygiene, two person assist for toileting and Hoyer lift for transfers. There was a focus of care for self care deficit, which included an intervention to turn and reposition the resident every two hours. The care plan initiated a focus of care on 09/23/25 for Resident #224 further revealed a potential for pressure ulcer development. Interventions included encouraging and assisting the resident to turn and reposition every two hours while in bed, and to follow facility policies and protocols for prevention/treatment of skin breakdown. The interventions also indicated the staff should encourage/educate the resident regarding the importance of changing positions every two hours and as needed for the prevention of pressure ulcers. Review of a Self Reported Incident (SRI) 267673 dated 11/17/25 revealed Resident #224 reported verbal abuse to the Administrator. She reported Certified Nurse Aide (CNA) #819 had told her she could poop her pants like everyone else here when the resident asked for assistance to the toilet. The resident had been having diarrhea and after assisting to the toilet the CNA allegedly told the resident she had been making up having diarrhea so she would be taken to the restroom first. The statement by the Administrator indicated the resident told her CNA #819 was always mean to her and called her a liar. The investigation included a statement, dated 11/18/25, from CNA #819, in which she indicated CNA #657 had been present at the time of the reported incident. CNA #819 indicated she made a statement to the resident I never said your name at all in my conversation with [CNA #657], and do not put words in my conversation with [CNA #657] saying I was talking about her. I said I never said her name and don't accuse me of saying anything about her. The investigation of SRI 267673 failed to include a witness statement from the present CNA #657 or a witness statement from her. This was confirmed in an interview with the Corporate Quality Assurance Nurse (QARN) on 05/13/26 at 10:44 A.M. Review of SRI 265706 failed to reveal the name of the alleged perpetrator for an investigation which alleged misappropriation of resident funds. On 05/13/26 at 10:44 A.M., the QARN confirmed the SRI investigation 267673 was an incomplete investigation. It failed to provide a witness statement from the CNA who had been identified as being present in the bathroom at the time of the incident. On 05/13/26 at 12:49 P.M., an interview with the Administrator revealed she did not list the name of the alleged perpetrator in the investigation of SRI 265706, which alleged misappropriation of resident funds. She further verified there was no witness statement or interview of the alleged perpetrator noted. She confirmed this was an incomplete investigation. Review of a facility policy titled Incident, Accident, and unusual occurrence investigation and reporting, revised 11/2024, revealed the purpose was to improve resident care and prevent or minimize re-occurrence of accidents/incidents through investigation, assessment, care planning and implementing interventions. The facility would review injuries/accidents to determine if the injury met the definition of an injury of unknown source which would require reporting to state surveys and certification agency or other officials in accordance with state laws. An investigation would include assessment of the resident, observation of the area and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365766	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Health Care Center	930 East Park Avenue Columbiana, OH 44408

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification of the attending physician and residents Power of Attorney. Any needed interventions would be put into place. The administrator or Director of Nursing (DON) would review the report and the initial investigation. The investigation would be completed and all steps would have been taken to prevent or minimize opportunity for reoccurrence. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2687730.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365766	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Health Care Center	930 East Park Avenue Columbiana, OH 44408

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and facility policy review, the facility failed to provide personal care assistance to a resident who was dependent on staff for care needs. This affected one resident (#221) reviewed for activities of daily living assistance needs. The facility census was 68.Findings include:Review of the medical record for Resident #221 revealed an admission date of 07/23/24. Diagnoses included Parkinson's disease without dyskinesia, repeated falls, insomnia, other symbolic dysfunctions, need for assistance with personal care, dysphagia, chronic kidney disease stage three, major depressive disorder, psychotic disorder with delusions, psychotic disorder with hallucinations, and Alzheimer's Disease. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four on a 0-15 scale. A BIMS score of 4 would indicate severe problems with thinking and memory. The MDS also indicated the resident had behaviors which included physical behavioral symptoms directed towards others such as hitting, kicking, pushing, scratching, grabbing and abusing others, as well as threatening, screaming or cursing at others. Further she had behaviors directed at herself such as hitting or scratching herself, pacing, rummaging, screaming and/or disruptive sounds. Review of a care plan initiated 11/22/23 and revised on 03/26/26 revealed a person centered plan of care with interventions that included a bed pad or chair alarm to alert staff of unassisted transfers, an assist of two for bathing and bed mobility, incontinence of bowel and bladder, and confusion. She required two staff assistance for toileting and transfers with a mechanical lift. She had interventions in place to remind the resident to use the call light and ask for assistance to prevent falls. There was a focus of care for incontinence of bladder initiated on 12/05/23 and revised 03/26/26. Interventions included checking and changing the resident every two hours and as needed, incontinence care, responding to resident's request to toilet or sign of distress as quickly as possible, and ensuring the call light was within reach. The care plan also had a focus of care for self-care deficits initiated on 12/05/23 and revised 03/26/26 related to dementia and Parkinson's disease. Interventions included providing assistance for resident to safely perform the task. Monitor the Resident's ability to perform Activities of Daily Living, and assist resident with meals per Activities of Daily Living Plan. Review of the medical record for Resident #221 revealed a task titled Turn and Reposition every two hours. This task indicated over the past month (04/12/26-05/13/26), the task to turn and reposition had been marked as no to indicate not completed on the evening shift on the following dates: 04/16/26, 04/17/26, 04/18/26, 04/19/26, 04/21/26, 04/24/26, 04/27/26, 04/30/26, 05/02/26, 05/03/26, 05/07/26, and 05/12/26. There was no documentation for the day shift on 05/03/26. This was confirmed by the Director of Nursing on 05/13/26 at 12:08 P.M. On 05/13/26 at 11:20 A.M., observation revealed Resident #221 in wheelchair in the dining room. There was a notable odor of urine about her. She was sitting with her spouse who was feeding her lunch. On 05/13/26 at 11:20 A.M., an interview with Resident #221's husband revealed he was her Power of Attorney. He reported he was concerned at times she was not checked for incontinence enough, and that made her bottom sore. He reported she goes a lot and her urine was strong, and she needed to get out of her wet brief as soon as possible, however every time he arrived it seemed like she was wet or soiled and needed to be changed. The facility would get her bottom healed up, and the next thing he knew it was breaking down again, and he felt it was due to the fact they did not change her or check her enough. He also worried if he was not there no one would help her eat. He had come in before and she would be in her room sitting with a tray in front of her and unless he helped her or told her what to do, she did not know how to feed herself on her own. On 05/13/26 at 12:08 P.M., an interview with the Director of Nursing revealed the staff did not chart check and change every two hours. They mark per shift in the electronic medical record (EMR). She confirmed the EMR indicated the identified resident was documented as not having been checked every two hours as noted in the care plan. On 05/13/26 at 12:20 P.M., an interview with Licensed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365766	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Health Care Center	930 East Park Avenue Columbiana, OH 44408

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse (LPN) #439 revealed Resident #221 often had behaviors which made it difficult to perform her care. The nursing staff had to keep reminding aides to do the best they could and they may need to go back several times to get the task completed. LPN #439 did not believe Resident #221 had any areas of concern on her bottom at the time. The goal was for the resident to be turned or up in a chair, cream on her bottom, positioned and changed. All of the things for her to be happy and healthy in our facility. She believed turning and repositioning residents was everyone's responsibility. On 05/13/26 at 1:20 P.M., an interview with the Wound Care Nurse, Registered Nurse (RN) #512 revealed Resident #221 had redness to her perineal area and bilateral buttocks. Resident #221 was a heavy wetter, which could only be assisted by frequent checking of the resident and changing her. As the wound care nurse, she did not consider this redness (also referred to as MASD or Moisture Associated Skin Damage) to be a wound, so she did not track it. Despite being a heavy wetter, she felt checking Resident #221 every two hours was sufficient for the resident to be checked for incontinence and changed. On 05/13/26 at 4:50 P.M., an observation and interview of Resident #221 revealed she was in bed with her dinner tray in front of her. She was sitting watching the television and not eating. She had spilled the pink drink on her tray. It appeared she had attempted to feed herself the chicken salad, however it was dropped on the tray and her silverware was lying on the tray. She indicated she was hungry and she attempted to pick up her silverware, but could not do so. When asked what she would do if she needed help, she reported she would call someone. When asked how she would call she stated with the phone and looked for her phone, which she did not have. The call light at this time was within reach. She did not know what to do with the call pad or to use it to call for assistance. This was confirmed by interview with LPN #439 and CNA #549 at the time of the observation. On 05/13/26 at 4:54 P.M., an interview with LPN #439 revealed the facility did not have an alternative system to use for residents who were not able to effectively use a call light or call pad system. She thought the best thing to do would be to have increased checking in place for the resident. She also indicated for Resident #221, because she had an increased amount of urination combined with the inability to use the call light system, should have more frequent checks and change times in place. She confirmed the resident was on an every two hour check and change schedule, however it probably should be more frequently, maybe at least every hour. She further confirmed Resident #221 required assistance to eat and she was not being assisted by anyone. She reported she would find someone to assist the resident. On 05/13/26 at 4:59 P.M., an interview with Certified Nurse Aide (CNA) #549 revealed Resident #221 could not eat independently. The resident had days where she could feed herself, but on those days she required queuing from someone to know to take a bite or to pick up her silverware. Left on her own, the resident would either not eat at all or would spill things all over her tray. Review of a facility policy titled Incontinence Care, revised 02/2026, revealed incontinence care was to prevent infection, odor, and skin irritation and to maintain resident comfort. Moisture barrier was to be applied after incontinence care, and the nurse was to be notified if redness or irritation was new. Review of a facility policy titled Pressure Ulcer Prevention and Care Protocol, revised 09/2025, revealed the licensed nursing staff of the facility would determine the risk of pressure ulcer development in development of the resident's plan of care. Identified risks would be documented in the resident's individualized plan of care. The protocol for protection against pressure ulcers, friction and sheer included but were not limited to: reducing pressure over bony prominences, turning and repositioning of the resident (the resident would be turned and repositioned at least every two hours or as outline in the plan of care based on a resident's individual needs, identified through assessment), assistance with transfers, ambulation and mobility as needed, protection of the skin from mechanical injury through the use of lift sheets, trapeze, etc., and monitoring for pressure caused by positioning or medical devices. The document further indicated a protocol to protect the skin from moisture. The protocol included toileting of the resident per schedule or at least every two hours if the resident was able to be toileted or check and change the resident every two hours and using briefs or absorbent pads to wick away moisture, as well as the use of lotion/cream on dry skin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365766	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Health Care Center	930 East Park Avenue Columbiana, OH 44408

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number 2687730 and 2603753