

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER Parkside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the nursing schedule, the [NAME] Staffing Data Report, the Facility Assessment, the facility punch detail reports and interview, the facility did not ensure a registered nurse (RN) worked eight consecutive hours a day seven days a week. This had the potential to affect all residents. The facility census was 54. Findings include: Review of the [NAME] Staffing Data Report for the second quarter of fiscal year 2025 revealed the facility triggered for no RN hours for 01/19/25, 02/15/16, 02/16/25, and 03/29/25. Interview on 07/31/25 at 2:00 P.M. with the Director of Nursing (DON) revealed the facility was short on RN's every other weekend due to a recent termination; however, the DON personally covered said shifts, and recruitment efforts to hire weekend RNs was ongoing. Review of the nursing schedule for the 03/29/25 revealed no RN was scheduled for that day. Review of the punch detail report for 03/29/25 confirmed six licensed practical nurses (LPNs) each worked at least eight hours; however, it did not reflect a RN worked that day on either the day shift or night shift. Interview on 08/05/25 at 6:10 P.M. with the DON confirmed there was no RN coverage that day. Review of the Facility assessment dated [DATE] revealed the facility would have one full-time RN, DON, one full-time Minimum Data Set (MDS) RN, and one full-time wound care RN as part of the staffing plan. The facility assessment did not speak to weekend RN staffing.		

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

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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 observation, interview, medical record review, and review of the facility policy, the facility failed to ensure proper infection control measures were adhered to during wound care for Resident #51 and catheter care for Resident #76. This affected one resident (Resident #51) of three residents who were reviewed for appropriate care and services for pressure ulcers and one resident (Resident #76) of six residents who had indwelling urinary catheters. The facility census was 54. Findings include: 1. Review of the medical record for Resident #51 revealed an admission date of 02/17/25 and a re-entry date of 06/25/25. Diagnoses included neuromuscular dysfunction of the bladder, Cauda Equina Syndrome, arthrodesis status (when two or more bones in a joint are surgically fused together), urinary retention, colostomy status, post-traumatic stress disorder (PTSD), radiculopathy and spinal stenosis with neurological claudication of the lumbar region, major depressive disorder, Hodgkin lymphoma, and an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) to the right buttock. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 07/01/25 revealed Resident #51 had intact cognition and was dependent on staff for toileting hygiene and bathing. Further review of the MDS revealed Resident #51 had two stage two pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) and one unstageable deep tissue injury (DTI) (A DTI is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) and was receiving pressure injury care. Review of the orders revealed an order dated 07/24/25 for Resident #51 to have the right ischial wound cleansed with Vashe wound cleanser-soaked gauze, patted dry, Skin-Prep (creates a protective barrier) applied to the surrounding wound bed, application of silver alginate (antibacterial wound dressing for moderate to heavily exudating wounds), and covered with a foam border dressing daily on day shift and as needed if it was soiled or removed. Observation on 07/30/2025 from 11:18 A.M. to 11:25 A.M. of wound care performed by wound Registered Nurse (RN) #313 revealed RN #313 removed the soiled dressing from the wound, then removed the soiled gloves from both hands, exposing another pair of gloves beneath. RN #313 wore the second pair of gloves (that had been worn underneath the top pair of gloves) to cleanse the wound. Using the same pair of gloves, RN #313 picked up the closed packet of silver alginate that had fallen on the floor and emptied the clean contents from the packaging (the silver alginate dressing) onto the clean field on the overbed table. RN #313 was then observed beginning to remove the right glove (the second layer of gloves) then pausing for a couple seconds while looking around the room. At that time, Nurse Aide Supervisor #362 instructed Student Nurse #399 to hand RN #313 another pair of gloves. RN #313 proceeded to remove and discard the soiled gloves, don a new pair of gloves, and continue with wound care. No hand hygiene was performed between glove changes. Interview on 07/30/25 at 11:35 A.M. with RN #313 confirmed the typical process for gloving and hand hygiene during wound care was to double glove and that it had been the normal process for RN #313 for several years out of habit. RN #313 further revealed that had the dressing supplies not fallen on the ground, wound care would have continued without an actual glove change because the top layer of gloves would have been removed between dirty and clean tasks. During this interview, RN #313 confirmed no hand hygiene was performed between glove changes. Interview on 07/30/25 at 12:20 P.M. with the Director of Nursing (DON) confirmed double gloving was not supposed to be standard procedure and that hand hygiene was to be performed between glove changes. Review of the policy titled Dressing Change (Clean), last revised February 2024, revealed that after the necessary equipment/supplies were set-up for the ordered dressing change, the nurse was to don non-sterile gloves, remove and discard the old dressing, remove gloves, perform hand (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene, and don a clean pair of gloves prior to cleansing and redressing the wound. The policy further noted that staff were to follow the facility's policy on hand hygiene. 2. Review of the medical record for Resident #76 revealed an admission date of 07/29/25 with diagnoses including permanent atrial fibrillation, oropharyngeal dysphagia, presence of implantable cardiac defibrillator, acute and respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), pulmonary hypertension, chronic kidney disease, need for assistance with personal care, and encounter for palliative care. Review of the assessment titled Admit/Readmit Screener - V 4 dated 07/30/25 revealed Resident #76 was alert and oriented to person, place, time, and situation. Further review of the admission assessment revealed Resident #76 had a 16 French Foley catheter with a five to 10 milliliter (ml) balloon catheter (a flexible indwelling tube inserted into the bladder to drain urine and secured by a balloon inflated with water) which required staff to perform catheter care. Review of the care plan dated 07/30/25 revealed Resident #76 had an indwelling urinary catheter. Interventions included the provision of Foley catheter care every shift and maintaining Enhanced Barrier Precautions (EBP) during direct resident care per facility and Centers for Disease Control and Prevention (CDC) guidelines for the duration of Resident #76's stay or until the indwelling urinary catheter was discontinued. Review of the order dated 07/31/25 revealed Resident #76 was to be on EBP for high contact resident care activities due to an indwelling medical device (Foley catheter). Observation on 07/31/25 from 2:55 P.M. to 3:05 P.M. of catheter care for Resident #76 performed by Certified Nurse Aide (CNA) #390 and assisted by CNA #391 revealed neither CNA donned a gown to perform catheter care. Further observation revealed there was an EBP sign on the room door of Resident #76, along with an organizer for personal protective equipment (PPE). Interview on 07/31/25 at 3:07 P.M. with CNAs #390 and 391 confirmed there was a sign and PPE on the door of Resident #76 and that Resident #76 was supposed to be in EBP because of a Foley catheter, and they did not put gowns on to perform catheter care. During the interview, CNAs #390 and #391 confirmed they should have put on a gown before performing catheter care. Interview on 07/31/25 at 3:57 P.M. with Corporate Nurse #398 confirmed residents with catheters should be in EBP which included donning a gown before providing catheter care. Review of the policy titled Enhance Barrier Precautions (EBP) effective March 2024, revealed EBP required donning of a gown and gloves during high contact resident care activities, including urinary catheter care and care of indwelling devices.		